Ontario

Royal Commission on Matters of Health and Safety Arising from the Use of Asbestos in Ontario

WORKERS' COMPENSATION AND ASBESTOS IN ONTARIO

A Study Prepared By:

Peter S. Barth

Study Series

Study No. 2

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for

The Royal Commission on Matters of Health and Safety

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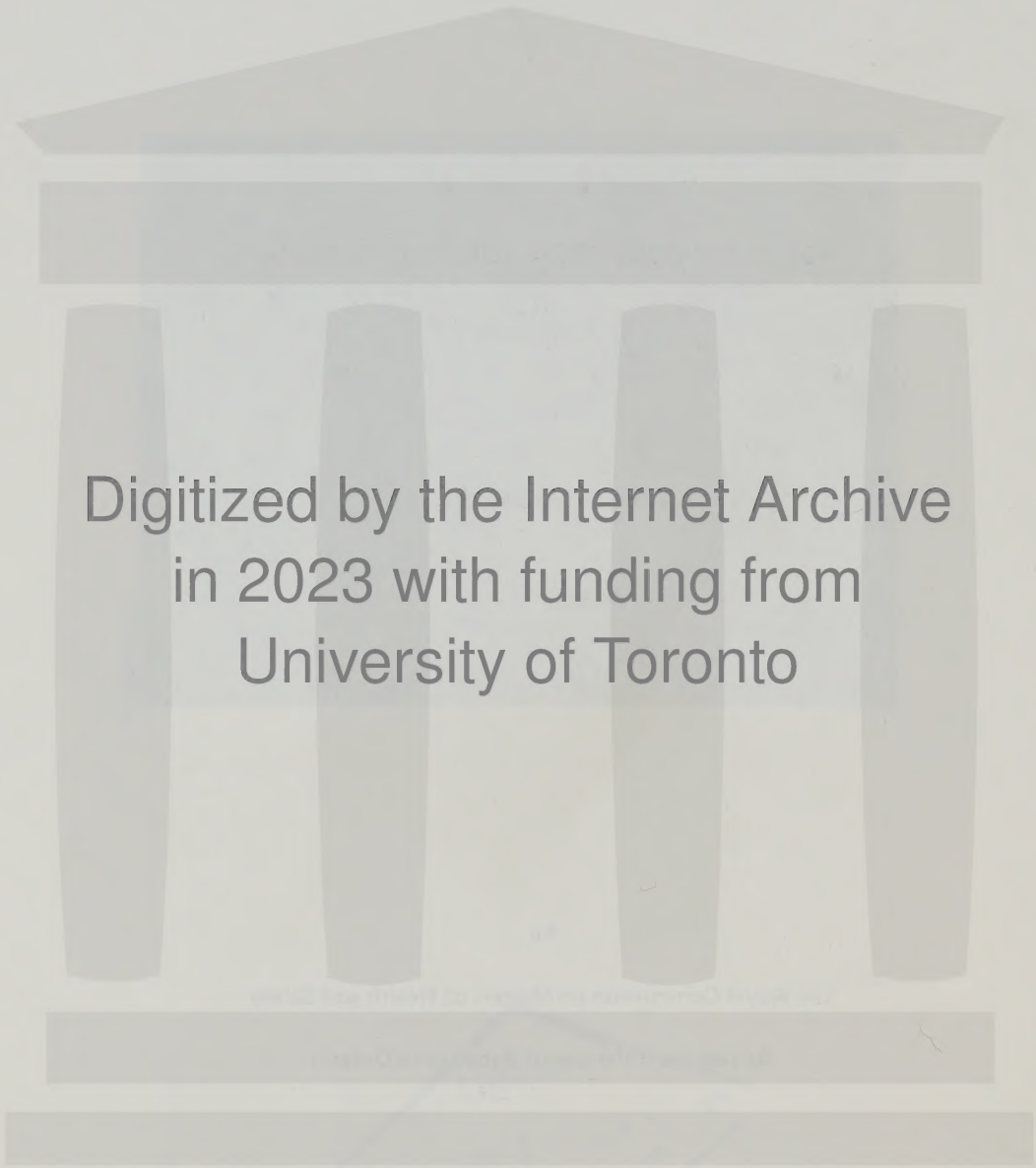
This study was commissioned by the Royal Commission on Asbestos, but the views expressed herein are those of the author and do not necessarily reflect the views of the members of the Commission or its staff.

January 1982



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Chapter I Introduction

The purpose of this study is to assist the Royal Commission on Matters of Health and Safety Arising from the Use of Asbestos in Ontario in its deliberations. Its sole focus is the problem of asbestos-related diseases in workers and the manner in which such persons are compensated by the Ontario Workmen's Compensation Board. It is beyond the scope of this study to examine the many other systems that are related somehow to asbestos diseases or to workers' compensation. Instead, the study seeks simply to shed light on how a social insurance scheme copes with a problem that is far more complex than the accidental injuries it was intended to deal with exclusively by its originators.

Much of this study is descriptive. Few persons understand the practices and limitations of a workers' compensation agency. I have found this to be as true in Ontario as in other jurisdictions with which I am familiar. It is essential that the interested parties share a common understanding of

how the programme is administered before any evaluation can be made and alternatives suggested. A basic goal of this study is to provide an objective description of how the system functions.

A second goal is to give special attention to certain problem areas. This is not done to criticize the agency, but rather to deal with those issues already brought to the attention of the Commission as areas of controversy, potentially in need of reform. The methodology employed by me was to gather available information about the process of seeking and paying workers' compensation for asbestos-related diseases in the province, and from this to construct a fair description of the system. The study has been carried out using six sources of information. These are:

1. Interviews with the interested parties. This includes individuals working for the Workmen's Compensation Board as well as representatives of industry, organized labour, lawyers, community legal workers, and others who have familiarity with, or interests in, the programme.

2. A review of transcripts of hearings of the Royal Commission as they pertained to this area. Additionally, any written submissions filed with the Commission by November 1981 that dealt with this subject were available to and read by me.

3. I was given memoranda prepared by staff at the Workmen's Compensation Board on a variety of matters dealing with this subject. While some of these had been prepared especially for the Commission, others were not. Included in this material were quantitative estimates of claims activity prepared by the staff in the Medical Services Division dealing with asbestos-related and other industrial diseases.

4. The Royal Commission asked that I enquire as to procedures and experiences that workers' compensation agencies in other provinces encountered in asbestos disease claims. Most agencies in Canada had so little activity in this regard that there was little point in visiting them. I did visit agencies in British Columbia and Quebec.

5. For a number of years data have been collected by the Workmen's Compensation Board on claims involving asbestosis or mesotheliomas. These data have been kept as a card file and until now have barely been analyzed. Individual claims data were provided by the staff, allowing me to construct a number of tables and perform some simple tabulations. Additionally, broadly similar data on fatality cases involving cancer from any source were also given to me.

6. I was given access to and read the claims files of 156 persons who sought benefits for asbestos-related diseases. This enabled me to better understand the process whereby a claim is accepted or denied. The claims files were randomly selected by me from all claims involving asbestos, though I intentionally read a disproportionately large number involving fatalities. My agreement with the Board was that I maintain the strict confidentiality of these files and that no reference be made in any of my work that would allow any individual's privacy to be violated or his name used. I was allowed to

prepare notes from these files but not to photocopy them or to remove them physically from the Board's offices. This review proved to be time-consuming but invaluable to me in the preparation of this study. The limits imposed on me by the Board created no difficulties.

The balance of this study is prepared along the following lines. First, there is a description of the claims procedures, including reference to the appeals process. Following this, I describe the benefits available to successful claimants. Next, attention is given to a group that figures especially prominently in these procedures in asbestos disease claims: the Advisory Committee on Occupational Chest Diseases. This is followed by a chapter that describes the method of setting guidelines for the agency to adjudicate claims for asbestos-related diseases. Chapter VI, which follows, contains much of the quantitative evidence presented in the study.

The Workmen's Compensation Board at one time undertook a programme to identify applicants for

compensation for asbestos-related diseases. This type of outreach effort is described in Chapter VII. In Chapter VIII another special programme by the Board is described, in this case one designed to remove workers with existing or incipient disease from continuing exposure to asbestos. Although this programme is still operative, sufficient evidence exists to allow it to be described and evaluated. The study is concluded and certain assessments are made in Chapter IX.

Chapter II Claim Procedures

In this chapter, I review the procedures followed in the typical claim involving an industrial disease. A case becomes a claim -- and receives a claim number -- for one of several reasons. The most common source or originator of claims is the disabled worker or a survivor. With asbestos, a very important variant of this has been where the union triggers the process. A large number of claims from the Johns-Manville operation came from the local union president, often, it seemed, with no prompting or even knowledge of the worker. A claim initiated by the employee -- or any party for that matter -- involves no formal application at the outset. A telephone call, note or visit to the Workmen's Compensation Board (WCB) office, indeed any type of enquiry, can begin the process. Based on a survey of actual claims for asbestos-related diseases, about 41 percent originated with the employee or a survivor, and about 31 percent began with the union notifying the WCB.

A significant number of claims originate with the employer, who may learn of a worker's health problems from a variety of sources. The motives for such notification are undoubtedly varied but there is no question that this has been an important source of claims. Based on the survey of claims for asbestos-related diseases, about 10 percent of claims originate with the employer.

The third major source of claims (about 18 percent) is from the health community. This includes a patient's personal physician as well as the specialist to whom a worker might have been referred. Additionally, physicians may come in contact with persons who have been hospitalized and who may have signs of an industrial disease. It is not uncommon for a physician to suggest to a patient that a claim ought to be filed and also to notify the WCB about a possible claim. This can result in two separate sources for what eventually becomes a single claim.

Regardless of the source, or how tentative an enquiry may be, the WCB treats it as the beginning of a possible claim and responds by requesting

information from three distinct parties. The WCB requests that a worker submit a Form 6-S, that a Form 8-S be given to his physician to be completed and returned, and that a Form 7-S be sent to the person's employer. (These forms are attached to the end of this chapter.) None of these is very elaborate and each can be completed in only a few minutes. On rare occasions the worker, despite repeated requests, did not return the completed 6-S Form. After several attempts to contact the worker and elicit some type of response, the claim was dropped. A number of claims for asbestosis that are considered rejected by the WCB were denied for this reason. In these instances the originating source of the claim was the union or an employer, not the worker.

I found no claims that were denied consideration because no physician would prepare the needed 8-S Form. On several occasions, the claim was processed without an 8-S Form. Where a worker believes that he is disabled but he has not seen a doctor, the company or plant doctor has occasionally filed the 8-S for the employee.

The Form 7-S is sent to the employer. This can create certain problems in the case of long-latent diseases such as those due to asbestos exposure. First, the employee may have encountered asbestos at more than one establishment. Several forms may need to be returned in these cases. The employee may have long since stopped working for the employer where he was last exposed to asbestos. In such instances the employer may no longer exist, or may have inadequate records regarding when the person worked, his exposure to hazards at the workplace or his last level of remuneration. If the worker's disability arose from an injury that occurred at a distinct time at the workplace, there should be no delay in the WCB's receipt of the necessary forms from the employer. For the reasons cited above, however, the entire claims process can be delayed significantly until the appropriate employer is located and responds.

The information received by the WCB on the three forms may allow the claim to be considered for compensation. If not, an investigation may be required. In an asbestos claim the issue most commonly requiring an investigation by WCB staff is

the extent of exposure, if any, to asbestos in the employer's establishment. This type of investigation, which can involve either the checking of records or the undertaking of tests in the field can delay the resolution of a claim for several months.

The claim is controlled by a claims adjudicator in the Industrial Diseases and Dependants Section. Here, the issues of coverage and the appropriate employer are decided. The claim is sent from there to the Medical Services Division where it usually is reviewed by the WCB's chest consultant, Dr. C. Stewart, or his colleague Dr. D. Dyer. (Both men serve as full-time staff of the WCB.) At this point the procedure to be followed depends on whether or not the claim is for asbestosis. In this respect (and a number of others) claims for asbestosis are subject to different handling from those for the other asbestos-related diseases. If the claim in question is <u>not</u> for asbestosis, a decision regarding compensability is made, essentially, by the Medical Services Division. This may be done simply by reviewing the claims file, which may contain only the completed 6-S, 7-S, and 8-S Forms as well as any

report prepared by the Claims Adjudication Branch. Alternatively, the Board's physicians may seek additional evidence which often may involve requesting records from hospitals, private physicians' reports and/or an assessment by a pathologist. If the latter is requested, this seems to involve invariably Dr. A.C. Ritchie of the University of Toronto. It is important to note that the process of acquiring such information often delays the resolution of a claim from anywhere between six weeks and six months. The longer delays usually occur where hospitals are slow to respond to requests for information, files, X-rays, tissue or the like. An asbestosis claim, on the other hand, is likely to be referred to a committee of specialists that advises the WCB's Medical Services personnel on how to respond to the claim. This procedure is described later in this chapter.

Once the needed information is provided, a decision is made by a WCB doctor and transmitted to the claims adjudicator. Out of 156 claims files examined by me, I found only one instance where this decision was challenged on its face in any way by the

claims adjudicator. In all other instances, the physician's judgement, both as to compensability and to the extent of the impairment, was the decision that was rendered to the claimant.

Any adjudicator's decision that is adverse to the claimant is reviewed in the Claims Review Branch (in the Claims Division). I found virtually no reversals by the Review Branch of the decisions made by either the claims adjudicator or by the Medical Services Division amongst the 156 files I read. At this point the claimant is notified of the decision. In the case of an adverse decision, the reason for the WCB's position is given in writing, and the employee or survivor is advised of his right to appeal. He is informed also of his right to receive assistance in an appeal from a workers' advocate, a staff person employed to assist claimants.

If the worker does seek to appeal the initial decision, the matter is heard by an Appeals Adjudicator, a staff person of the WCB. This is a relatively formal process with a decision rendered in writing after the hearing has been held. An appeal can be made of this decision to a three-person panel

of Commissioners of the Board. This proceeding is a formal one and a written decision is provided to the claimant. This final appeal involves a hearing where the worker is customarily represented by counsel or a union representative. The Board has, in some cases, asked for additional information including independent medical opinion at this stage.

For most purposes, a claimant's rights are exhausted with this appeal to the Board of Commissioners. In theory, however, there are three avenues of appeal, or at least review, that remain potentially available to the claimant. First, while the statute could hardly be clearer or more decisive in the matter of the conclusiveness of the Board's decision, the worker or survivor may seek redress in the Supreme Court of Ontario under The Judicial Review Procedure Act (R.S.O. 1980, c.224). This possibility, in asbestos or non-asbestos cases, is exceedingly small and the Court will limit these cases to ones where the issue is one of jurisdictional error. In a recent, significant decision, the Divisional Court held that the WCB had made an error of law in setting an award and that the WCB, by answering a question not referred to it by the statute, and

ignoring one that was so referred, had moved outside of its jurisdiction. [See Gianoukakis v. WCB, 21 O.R. (2d) 246.] Issues such as the extent of impairment or etiology would not be reviewed though these are generally the critical ones in asbestos claims. The second alternative that the claimant has is to bring the decision to the attention of the Ombudsman. (See The Ombudsman Act, R.S.O. 1980, c.325, ss.15 and 22.) This is rarely sought in any type of workers' compensation matter and the finding by that office is not binding on the WCB. Even if the worker's position were sustained by the Ombudsman, there is no assurance that this would lead to a reversal by the WCB.

The third alternative is to ask the WCB to re-open a claim, that is, to reconsider a decision after a claim has been decided by a Board of Commissioners. The basis for such a reconsideration in practice is that new evidence or circumstances have developed or come to light since the decision was initially rendered.

There can be no dispute that there exists within some quarters considerable dissatisfaction

with either the manner in which the WCB has decided claims for asbestos-related diseases or the outcomes of specific claims. The transcript of the hearings of the Royal Commission on Asbestos as well as the submissions presented attest to this. On that basis one might anticipate that the routine claim has involved appeals by workers or survivors from the claims adjudicator level and perhaps beyond this from the appeals adjudicator level. The facts, however, do not square with this. The survey of claims files involved 156 cases, 69 of which were rejections by the WCB and 87 of which were (ultimately) accepted by the Board. It is important to observe at least two things about these cases. First, dissatisfaction and appeals can and do occur even in cases that the WCB accepts. For example, the Board may decide to pay for medical benefits but not to provide compensation. A more common ground for dissatisfaction in an accepted claim is that the estimate of the extent of disability, and thereby the size of the award, is thought by the worker to be inadequate.

A second ground for caution in interpreting these data is that a given claim, accepted or otherwise, actually can involve several different

decisions, any one of which can result in appeal. For example, in one year a claim may be rejected, the following year a 10 percent permanent disability award is made, and the following year that award is reconsidered and maintained at the 10 percent level. That single claim actually should be viewed as three separate sets of judgements, any of which might have led to an appeal.

Of the 69 claims that were not accepted by the WCB, there were only 8 requests for reconsideration. In the 87 cases that were accepted at some stage or other by the WCB, there were 10 appeals by the claimant. It should be noted that these were considered as appeals by me if the claimant requested a reconsideration, even if the claimant subsequently dropped the matter and did not actually pursue the claim as was often the case. For example, one claimant appealed a decision by the claims adjudicator and wrote that his appeal would involve his obtaining a letter from a renowned medical expert on asbestos-related diseases. Apparently, the letter was never obtained or its support was thought to be inadequate as the claimant did not then follow-up on the appeal.

Most of the appeals that were undertaken went only as far as the appeals adjudication level. Most of the appeals involved a medical issue, either etiology or the extent of impairment, and only a few resulted in a change of position by the WCB. It is difficult to determine why so few appeals were made by claimants. Some workers' advocate groups, such as the legal aid clinics and some unions, argue that appeals are usually ineffective and that the claims adjudicator's position is most commonly upheld. Whether that is correct or not, what would seem to matter more is the perception that an individual claimant has regarding the claims process. Moreover, even if the perception -- correct or otherwise -- is that an appeal has little chance of reversing a judgement adverse to the claimant, what harm is there in making an appeal? The claimant incurs no direct cost since a union (or, less commonly, a workers' advocate) will not bill the worker for aiding him in an appeal. There is, of course, some time commitment involved but this is small and even trivial when compared with a suit in court.

The majority of cases for asbestos-related disease involve workers who claim to have asbestosis.

This form of pneumoconiosis is evaluated somewhat differently by the WCB than are claims for other asbestos-related diseases, though the appeals process is the same. Once the claim is forwarded by the claims adjudicator to the Medical Services staff, it is screened by either Dr. Stewart, the chest consultant, or by Dr. Dyer. Typically, they will review the claim file, including the doctor's report on Form 8-S, and will examine X-rays of the worker's chest that are often available from the Ministry of Labour. This screening is more than a pro forma one. Based upon it the physician will advise the claims adjudicator whether or not to schedule the worker for an examination by the Advisory Committee on Occupational Chest Diseases (ACOCD). The WCB procedures require that a worker be evaluated by the ACOCD in order to be compensated for asbestosis. (Exceptions to this include cases where the worker is already hospitalized or the claim is from a survivor.) If the Board doctors believe that no reasonable basis exists for a claim, the matter will not be referred to the ACOCD. In those cases the Board doctors effectively cause the claim to be rejected. In the survey of claims files that I undertook, there were 101 claims involving only asbestosis. (A number of

cases involved asbestosis and another asbestos-related disease and are not considered here.) Of these, 54 were not accepted by the WCB at least as of the time of the survey. Overall, 27 cases involving claims for asbestosis were rejected by Dr. Stewart or Dr. Dyer and not referred to the ACOCD. The most recent claims (1980-81) tend to have the greatest likelihood of being denied without referral to the ACOCD.

An examination of the claims files reveals an asymmetrical pattern of response by the Board's staff doctors. When a claimant's doctor reports that a worker is suffering from asbestosis, that physician's report is not considered definitive. The WCB and the ACOCD will make an independent determination of the person's condition in order to decide whether or not there is a disability, its cause and its extent. However, in 27 claims of those sampled the case was not fowarded on to the ACOCD, apparently because of a negative report on the 8-S Form. For example, if a worker's doctor reported that the man was in good health, or perhaps that his illness was due to bronchitis (not compensable), the Board doctors might accept this report on its face and decide that the claimant would not be examined by the Advisory Committee.

Two factors explain why a claimant's physician's argument is not accepted at face value by the Board's doctors. First, there could be a lack of objectivity on the part of the worker's physician. In a province as large as Ontario one may expect to find some doctors who would regularly report finding disabling asbestosis in any worker with pulmonary-respiratory problems. The second reason given is that asbestosis is not a simple disease to diagnose or evaluate and therefore only experienced specialists are well equipped to do so. This argument could lead one to discount heavily the value of diagnosis by a worker's own doctor, at least when the physician is not a specialist in such diseases, but that applies regardless of the physician's assessment. Restated, if the second reason given above is a legitimate one, Board doctors should consistently reject these assessments, both when they uphold a claimant and when they do not. This is not the situation presently.

If the Medical Services Division decides that a claimant should be seen by the ACOCD, an appointment is scheduled. Expenses incurred in

keeping that appointment are reimbursable to the worker. The worker is interviewed, examined and subjected to various medical tests. One of the ACOCD physicians performs the tests and reports his findings to the full Committee. This process is not a speedy one and I believe that some Board staff are correctly sensitive to the delays involved. From the time that a routine asbestosis claim is filed until the ACOCD reports its findings to the Board's chest consultant, six months usually have elapsed. Much of the delay occurs between the examination and the preparation of a report for the WCB. The process used by the ACOCD is described elsewhere in this study.

The ACOCD must make two critical decisions as well as some lesser ones. First, the ACOCD must decide if the claimant suffers from an asbestos (or other work-related) disease. This question has essentially two parts: Does the individual show evidence of some form of chest disease and are the symptoms and exposure history consistent with asbestos-related disease?

Based upon a reading of the ACOCD's reports to the WCB's chest consultant, it is clear that while

several tests are employed in reaching a judgement, the most significant in determining the presence of asbestosis is the X-ray pictures of the chest.

The symptoms of asbestosis are not unique and evidence of disease may not prove that the worker has asbestosis. A biopsy may show the presence of significant amounts of asbestos in the lung, but such tests have too many risks to perform them solely to determine compensability. Therefore, the ACOCD makes its decisions regarding diagnosis and etiology based upon the worker's job history and any other pertinent data provided by WCB staff. For example, it will learn such things as the period of the worker's exposure to asbestos, and his proximity to it. Based on this evidence, in conjunction with X-rays, pulmonary function tests and the like, the ACOCD decides the first question. In practice the claims for asbestosis that the WCB has denied have been rejected primarily because the ACOCD could not find evidence of chest disease due to asbestos.

A. Assessing Permanent Disability

If the ACOCD finds that the worker has asbestosis, or another asbestos-related illness, the

second question to be resolved is the extent of impairment. At this point it is imperative that the distinction between disability and impairment be made definitive. Disability is the socio-economic consequence of some physiological or psychological damage or loss. A measure of disability could include the actual or potential loss of earnings associated with the condition. For example, temporary total disability compensation benefits are set as a proportion of a worker's lost earnings and, therefore, are based on the concept of disability. By contrast, impairment is a medical or health-based concept and not a socio-economic one. It focuses on the difference between some idealized measure of a healthy individual at some given age and the person after the condition in question has stabilized. Workers' compensation agencies vary widely in their approaches to compensating workers who have suffered a loss due to an injury or illness arising out of,and in the course of,employment. Yet all of them can be categorized by their basic approach to permanent disability awards as either using disability or impairment as the criterion for a compensation award. (Some jurisdictions use both approaches but these essentially add one type of award on top of the other.)

The basic approach to permanent disability awards in Ontario at the present time is to use impairment and not disability. This derives from section 43 of The Workmen's Compensation Act (R.S.O. 1980, c.539).* It is expressed in correspondence from the WCB to an asbestotic worker who was dissatisfied by an award of only 10 percent for permanent disability: "When an injured employee is assessed for permanent disability, it is done on the basis of estimating the impairment of that injured employee's earnings capacity, considering only the nature and the degree of the organic disability that solely results from a compensable accident. These awards are paid in accordance with all sections (sic) of 42 of The Workmen's Compensation Act of Ontario...."

This impairment approach -- which apparently is used in assessing all permanent disability claims in Ontario, whether for injury or disease -- is necessarily undertaken by a health specialist; for example, a physician, physiologist, etc. Since the WCB puts the evaluation of the extent of impairment in the hands of Board doctors -- or in asbestosis claims with the ACOCD -- any variation

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*Previously R.S.O. 1970, c.505, s.42; as amended by S.O. 1975, c.47, s.6(1).

from the strict impairment approach is implicitly left to these physicians. For example, taking account of the worker's difficulties in the labour market due to his health problem and his age suggest a deviation from a strict impairment approach. This implicit disability consideration is also left to the physicians, though their expertise is actually grounded in the impairment evaluation. In reality, there appeared to be very few instances where the ACOCD or the WCB assessed an asbestotic on other than impairment grounds. This appears to be in line with WCB Directive 2(d) of December 7, 1955, for assessing silicosis and pneumoconiosis claims: "The percentage ratings are to be based on clinical findings, but where special consideration is considered warranted, the circumstances are to be outlined."

The difficult issue of permanent disability assessment -- which appears to be a fundamental problem for most compensation agencies in North America -- is made more complicated by the apparent indecisiveness of the WCB. A directive issued in January 1980, 5(c), appears to blend disability with impairment as the basis for assessing compensation

awards to workers with job-related skin ailments: "The pension award is to be based on an estimate of the loss of earning capacity with review in one or two years, and where the patient is 60 years of age or over and has been disabled at least three years since the onset of the occupational contact dermatitis, a life pension may be awarded with review at intervals of two years." The fact that the worker's age is considered a determinant of how to deal with the claim may be suggestive of a disability approach rather than a strict impairment measure.

The mixture of the disability and impairment approaches was cautiously sanctioned by the WCB on June 2, 1978 (see Directive 13). While the issue that triggered the directive was salmonella poisoning in hospital workers, there is no indication that the policy is limited to these cases. "The Board on considering the question of interpretation in relation to "disability" directs that for interpretative purposes with respect to The Workmen's Compensation Act, disability shall not only represent physical disability, but also shall apply to a non-physically disabling condition which bars the employee from

earning full wages where the condition is connected with the employment and medically certified."

The Directive proceeds to explain that this policy would lead to compensating a worker, though not "disabled," who is forced to leave all work or who must be removed from an employment where there is continuing and potentially harmful exposure to a hazard, thereby incurring some earnings loss. It must be noted, however, that a medically rooted assessment is still the apparent guide in cases where the worker is impaired (or in the directive's terms, "physically disabled").

How does the ACOCD decide the specific rating of an impairment in a claimant? There are no specific, defined guidelines for the Committee to use, however, it is clear that a modus operandi has evolved over the years. It seems broadly consistent with the recommendations of the Task Force on Occupational Respiratory Disease chaired by Dr. G.L. Ostiguy, University of Montreal. The Task Force was created in 1977 by the Department of National Health and Welfare, in conjunction with the Canadian

Thoracic Society, to develop criteria both for diagnosing certain pneumoconioses, including asbestosis and for assessing "impairments" from them. A member of the Task Force is a consultant to the ACOCD and has been used by the WCB on numerous occasions to resolve difficult questions in pulmonary-respiratory claims.

The Task Force proposed that the clinical diagnosis of asbestosis be based on:

1. Essential elements:
    a. A history of "significant" exposure to asbestos dust. (Quotes added)
    b. Small irregular opacities on the chest X-ray, category 1 changes according to the ILO U/C 1971 classification.

2. Confirmatory elements:
    a. Evidence of restricted pulmonary function.
    b. Progressive shortness of breath on exertion.
    c. Inspiratory crackling rales at both lung bases.
    d. Clubbing of fingers and/or toes.

3. Pathological element:

    a. Evidence of interstitial fibrosis with a "sufficient" number of fibres or ferruginous bodies. (Quotes added)

The Task Force placed considerable importance on the X-rays for identifying the presence of asbestosis. Pulmonary function tests are also helpful in this regard. The X-rays, however, are thought to be of no value in assessing the degree of impairment. Instead, a variety of technical tests, including forced vital capacity, forced expiratory volume in one second, diffusing capacity for carbon monoxide, maximum oxygen up-take with exercise and partial pressures of arterial blood gases at rest were recommended as the basis for assessing impairment.

The ACOCD and the Board physicians closely adhere to the recommendations of the Task Force in one other significant way. The latter found that the presence of asbestos fibres or of pleural plaques in workers was not <u>per se</u> disabling. In case after case rejected by the WCB, the ACOCD found one or both of

these conditions and judged them as inadequate, by themselves, for purposes of awarding compensation.

A difference arose between the ACOCD and the Task Force (prior to the report being issued) in a claim that began in 1975. It illustrates the complexity of some of these questions. It also represented one of only two occasions where the WCB's chest consultant rejected a recommendation of the ACOCD, out of the 156 cases surveyed. It involved a diagnosis of pleural effusion, a condition that the Task Force was to find a suspected but not firmly established result of asbestos exposure.

A union representative began a claim for a worker exposed to asbestos. Based upon normal X-rays, pulmonary function tests within normal limits, and no abnormality in the heart, lungs or chest cage, the claim was not accepted. In 1977 the worker asked for reconsideration based on the possible presence of mesothelioma. The worker was then seen by the ACOCD, which in turn prepared an uncharacteristically tentative recommendation, namely that the "...man should probably receive compensation

during his illness because there is probably some association between asbestos exposure and pleural effusion." The Board's doctor in this case, as noted above, rejected the ACOCD's recommendation and the claim, explaining the reason in a note to the file: "Obviously, there is no asbestosis and,therefore, we have no responsibility so far in this claim, although I suppose that an acute pleural effusion in a long-time asbestos worker is generally considered to be due to this exposure and may result spontaneously or be the forerunner of a malignant mesothelioma. At this stage it is impossible to tell. However, it is known that pleural effusions in asbestos workers are more frequent than in those non-exposed. As far as I know we have not accepted pleural effusions in individuals who do not show signs of asbestosis, although there is an argument that we should do so in long-time exposure."

It should be noted that another difference, in this case between the WCB and the Task Force, exists in the acceptance of some cancer claims. The Task Force took an agnostic position on the role of asbestos in cases of laryngeal cancer or of lung

cancer in the absence of asbestosis in non-smokers. Ontario's WCB accepts either as potentially compensable.

The ACOCD assesses not only the extent of impairment in the claim involving asbestos, but also sorts out precisely how much of an impairment is due to asbestos. The files reveal that it is very common for an asbestotic worker to be suffering from other illnesses as well. Many applicants for compensation for asbestosis are older workers and these other conditions may or may not be caused or aggravated by the asbestosis. This issue, discussed in more detail elsewhere in this study, has led to immense difficulties for the WCB. In any case, the ACOCD recommends to the WCB the extent to which a worker's impairment is due to asbestosis or some other compensable pneumoconiosis. No formal guidelines exist for the ACOCD on how to sort this out. Nevertheless, the ACOCD must regularly confront such questions.

The ACOCD will customarily re-examine a claimant, regardless of any initial disposition of a claim. Only when the worker appears to be in generally good health will no follow-up examination

occur. The frequency of follow-ups depends primarily on the severity of the condition, and the extent to which it has stabilized. Further, it appears that where the ACOCD is uncertain about a condition, it may request an opportunity to re-examine the person relatively quickly.

Virtually all the cases involving asbestos that go to the ACOCD are for asbestosis claims. For the sake of accuracy it should be noted that on some occasions claims for asbestos-related diseases not involving asbestosis are referred to the ACOCD. The Committee has evaluated these and recommended action based on its assessment of impairment. Why these few claims seem to slip through to the ACOCD is unclear. It may simply be that the frequent resort to this Committee causes an almost habitual response where asbestos is implicated. Moreover, since cancers frequently develop in asbestotics that the ACOCD will probably have seen, they are not unfamiliar with this disease and its implications.

B. British Columbia and Quebec

The approach to dealing with claims for asbestosis is significantly different in Quebec.

Workers in asbestos mines are given chest X-rays every year and these are all sent to the Commission des Accidents du Travail du Québec. Certified "B" readers examine all X-rays and if any anomalies compatible with asbestosis are seen the worker is examined by a three-person panel of pneumonologists. Twelve experts work in four teams of three physicians each and they are assigned examinations on a rotation basis. Unlike the ACOCD, all three are present for parts of the examination, which can take up to two days. The panel is responsible for making a diagnosis and estimating the extent of impairment.

In Quebec, any claim for asbestosis by an eligible worker is seen by one of the medical panels. There is no medical screening by the Commission in Quebec to determine whether or not a claimant should be examined by a panel, unlike the situation in Ontario. Approximately once a month all the panels meet and review each other's recent findings and decisions. This assures that some uniformity will prevail, regardless of which panel a worker encounters.

Another comparable type of internal check used by the Quebec Commission is when a pathologist's

decision is needed. For example, if a question arises on the site of the primary tumour, the Commission will use two pathologists working independently. No such practice is used by the Ontario WCB and indeed, I have found only one pathologist consistently being used in asbestos cases by the Medical Services Division. In fairness it must be noted that I have encountered no criticism of either this procedure or of this expert's findings in my study.

The members of these Quebec medical panels are drawn from faculty of the four medical schools in that province. In recent years they have evaluated about 400 persons a year. Adverse decisions affecting claimants can be appealed within the Commission to a Review Board. This body rarely changes a decision of the medical panels. It is composed of Commission personnel. Beyond this level a claimant is entitled to appeal on matters of fact or of law to a Social Affairs Commission, a three-member group appointed by Quebec's premier. Currently, a decision by this group may take up to two years from the date that the appeal reaches it. Most decisions are based solely on a review of the case file. In a few

instances the Social Affairs Commission will ask for the medical opinion of a previously uninvolved physician.

In marked contrast to the systems in Quebec and Ontario, the British Columbia approach involves no outside panel of medical experts in routine claims. The typical claim for permanent disability for asbestos-related disease is seen by a single staff doctor, who customarily examines all such claimants. On the basis of his recommendation, the diagnosis and extent of impairment are set. There are two factors which can explain why so simple, direct and inexpensive an approach has survived, with seemingly little controversy. First, British Columbia has been fortunate to have had far fewer claims for asbestosis than have Ontario or Quebec. Secondly, British Columbia is one of a minority of provinces to use in appeals outside medical review panels with the power to make binding determinations. Claimants or their representatives have access to an independent, professional forum to express any dissatisfaction that they may have with the medical judgement rendered by the Workers' Compensation Board staff.

C. APPENDIX

THE WORKMEN'S COMPENSATION BOARD, ONTARIO:

FORMS

E WORKMEN'S COMPENSATION BOARD, ONTARIO

LOOR STREET EAST, TORONTO M4W 3C5 • TELEPHONE (416) 965-8804

EMPLOYEE'S REPORT
OCCUPATIONAL DISEASE

ESSAGE TO EMPLOYEE

ERE IS A DOCTOR'S REPORT FORM
CHED, PLEASE TAKE IT TO YOUR DOCTOR
COMPLETION.

NAME

NAME(S)

AL ADDRESS

OR TOWN

AL INSURANCE NO. — —

PHONE NO.

	WEIGHT	HEIGHT FT. INS.	SEX	MARRIED	SPEAK ENGLISH?	OCCUPATION

NAME AND ADDRESS OF EMPLOYER WHERE YOU CLAIM YOU WERE LAST SED TO DUST.

ESS

DATE YOU FIRST ENTERED THAT EMPLOY

DATE YOU LEFT THAT EMPLOY

IF OFF WORK NOW, GIVE DATE AND HOUR OF LAYOFF.

HAVE YOU PREVIOUSLY MADE A CLAIM FOR OCCUPATIONAL DISEASE

FULL PARTICULARS OF YOUR EXPOSURE TO DUST SHOWING NAMES OF EMPLOYERS WITH DATES ERIOD OF EMPLOYMENT WITH EACH EMPLOYER.

IN ONTARIO

EMPLOYER'S NAME	FROM	TO

OUTSIDE ONTARIO

EMPLOYER'S NAME	FROM	TO

OF BIRTH

MINERS CERTIFICATE NO.

LARE ALL THE ABOVE IS TRUE AND CORRECT AND I CLAIM COMPENSATION AND/OR MEDICAL AID.

D THIS DAY OF 19 CLAIMANT SIGN HERE

6S
(07/78)

THE WORKMEN'S COMPENSATION BOARD, ONTARIO
2 BLOOR STREET EAST, TORONTO M4W 3C5 TELEPHONE (416) 965–8804

EMPLOYER'S REPORT OCCUPATIONAL DISEASE

MESSAGE TO EMPLOYER

This employee is claiming compensation for disability due to industrial disease.

AGE	SEX	MARITAL STATUS	SOCIAL INSURANCE NO.	OCCUPATION

DATE EMPLOYEE ENTERED YOUR EMPLOY	MINER'S CERTIFICATE NO.

	NO	YES
IS THE INJURED EMPLOYEE THE OWNER OR PARTNER IN THE BUSINESS OR A CONTRACTOR, SUB-CONTRACTOR OR WIFE OR HUSBAND OF THE EMPLOYER? DOES EMPLOYEE HOLD THE OFFICE OF PRESIDENT, VICE-PRESIDENT, DIRECTOR, SECRETARY OR TREASURER?		
IS EMPLOYEE A RELATIVE OF THE EMPLOYER?		
DO YOU ALLEGE THAT THE DISEASE WAS CONTRACTED IN THE EMPLOYMENT OF SOME OTHER EMPLOYER?		

EXPLAIN "YES" ANSWERS ON BACK OF FORM IF NECESSARY

GIVE FULL PARTICULARS INCLUDING DATES AND GRADES OF WORK OF THE EXPOSURE.

FROM	TO	GRADE OF WORK

SHOW TOTAL EARNINGS FOR 1 YEAR (52 WEEKS) IMMEDIATELY PRIOR TO THE CURRENT PAY PERIOD.

TOTAL EARNINGS	DATES OF PERIOD COVERED BY EARNINGS FROM	TO

SHOW CAUSE OF LOST TIME WITHOUT PAY

NO. OF DAYS LOST

HOLIDAYS	SICKNESS	LACK OF WORK	OTHER (SPECIFY)

DATE	OFFICIAL TITLE

SIGNATURE	PHONE NO.

: WORKMEN'S COMPENSATION BOARD, ONTARIO
OOR STREET EAST, TORONTO M4W 3C5 • TELEPHONE (416) 965-8804

DOCTOR'S REPORT
OCCUPATIONAL CHEST DISEASE

ease answer ALL questions
lly and enclose copies of
nsultation and biopsy re-
rts relating to this disability.

PTOMS AND COMPLAINTS (WITH DURATION)

MINERS CERTIFICATE NUMBER

T ILLNESSES

MONIA	☐	BRONCHITIS	☐
RISY	☐	RHEUMATIC FEVER	☐
RCULOSIS	☐	DIABETES	☐
MA	☐	OTHER	☐

IF POSITIVE, GIVE DETAILS AND DURATION.

SICAL EXAMINATION — CHEST AND CARDIOVASCULAR

IRATION - MAXIMUM	EXPIRATION - MINIMUM	EXPANSION - INCHES

ORMAL FINDINGS

OD PRESSURE	HEART RATE
THM	SIZE

RT SOUNDS	HEIGHT	WEIGHT	
		PRESENT	USUAL

TUBERCULIN TEST
WHERE? | WHEN?
RESULT

SPUTUM EXAMINATION
WHERE? | WHEN?
RESULT

LUNG BIOPSY/THORACENTESIS
WHERE? | WHEN?
RESULT

CHEST X-RAY
WHERE? | WHEN?
FINDINGS

PNEUMOCONIOSIS PRESENT?
TUBERCULOSIS PRESENT?
READER

MARKS

GNOSIS

E OF EXAMINATION | SIGNATURE OF EXAMINER

2 Bloor Street East
Toronto, Ontario
M4W 3C3
Telephone (416) 965-8804

The Workmen's Compensation Board

Claim:

The Advisory Committee on Occupational Chest Diseases reports there is no change in your classification as a silicotic. Your award, therefore, has been confirmed for the present.

Your case will be followed and you will be advised when re-examination is considered necessary.

If you have any reasons for objecting to this decision or have any concerns or questions about the matter, please let us know as soon as possible.

When writing to us, please include both your claim number and address. To avoid delays, all address changes should be reported promptly by letter.

Yours very truly,

Claims Adjudication Branch.

2 Bloor Street East
Toronto, Ontario
M4W 3C3
Telephone (416) 965-8804

The Workmen's Compensation Board

Dear

Claim S

Your recent examination indicates that there is no evidence of an Industrial Chest Condition.

Your case will be followed closely and you will be advised when re-examination is necessary.

If you have any reasons for objecting to this decision or have any concerns or questions about the matter, please let us know as soon as possible.

When writing to us, please include both your claim number and address. To avoid delays, all address changes should be reported promptly by letter.

Your very truly,

Claims Adjudication Branch.

2 Bloor Street East
Toronto, Ontario
M4W 3C3
Telephone (416) 965-8804

The Workmen's Compensation Board

Dear

Claim S

Your recent examination indicates that there is no change in your industrial chest condition.

Your case will be followed closely and you will be advised if re-examination is necessary.

If you have any reasons for objecting to this decision or have any concerns or questions about the matter, please let us know as soon as possible.

When writing to us, please include both your claim number and address. To avoid delays, all address changes should be reported promptly by letter.

Yours very truly,

Claims Adjudication Branch.

2 Bloor Street East
Toronto, Ontario
M4W 3C3
Telephone (416) 965-8804

The Workmen's Compensation Board

Dear

Claim S

Your claim for an industrial chest condition has been allowed and permanent partial disability has been assessed at percent. You have been awarded a pension of $ a month. This pension dates from and will be paid so long as the disability continues.

Your case will be followed closely and you will be notified if re-examination is necessary.

If you have any reasons for objecting to this decision or have any concerns or questions about the matter, please let us know as soon as possible.

When writing to us, please include both your claim number and address. To avoid delays, all address changes should be reported promptly by letter.

Yours very truly,

Claims Adjudication Branch.

2 Bloor Street East
Toronto, Ontario
M4W 3C3
Telephone (416) 965-8804

The Workmen's Compensation Board

Dear

Claim S

Recent examination indicates that you are entitled to a higher disability rating and this has been increased to percent. Accordingly your pension for permanent partial disability has been increased to $ a month, dating from This pension will be paid so long as the disability lasts.

Your case will be followed closely and you will be notified if re-examination is necessary.

If you have any reasons for objecting to this decision or have any concerns or questions about the matter, please let us know as soon as possible.

When writing to us, please include both your claim number and address. To avoid delays, all address should be reported promptly by letter.

Yours very truly,

Claims Adjudication Branch.

Chapter III Benefits

In most respects benefits for workers with asbestos-related disease or their survivors do not differ from those available to other workers who have been disabled from work-related injuries or illnesses. Workers with compensable asbestos-related diseases receive medical and hospital expenses and cash benefits when temporarily or permanently disabled. Temporary total or permanent total benefits are set at 75 percent of the worker's gross earnings prior to disability, subject to an earnings ceiling currently set at $18,500/year. In temporary total disability cases the earnings basis is the worker's earnings in the four-week period prior to the injury. For pensions based upon permanent disability, the earnings basis is linked to average earnings during the twelve-month period preceding disability.

Asbestos disease (or other disease) claims tend to differ from those due to traumatic injuries occurring at a specific time and place at work and

these differences affect benefits. For example, there is no single instant that can be identified as the time that disability from disease began and, hence, there must be some arbitrary judgement as to when compensation benefits should begin or have begun. The large majority of compensable claims, particularly for asbestosis, involve no temporary awards. Thus, the sole award is a pension based de facto on the recommendation of the ACOCD. Prior to 1975, the pension benefits were dated from the time of the worker's examination by the Committee. Clearly, this imposed a direct cost on workers who encountered delays in being examined by the ACOCD, often through no fault of their own. Early in 1975 the WCB policy was changed and the initial date for pension eligibility was set back to when the X-ray was taken that prompted the submission of the claim to the Board.

In cases where a worker is denied a pension but subsequently is re-examined and found to be compensably impaired, the date of the award is typically set at the date of the re-examination. In either situation the WCB has the authority to set the

initial date for pension earlier. To do so requires approval by the Medical Services Division. Instances of this have been found in my survey of claims files though it is not a common occurrence. It must be noted, however, that these judgements are often arbitrary since no definitive basis exists for setting an appropriate date.

Asbestosis or cancers related to asbestos usually involve only permanent disability or survivors awards. There are few exceptions to this. One that occurs is when the ACOCD or the Medical Services Division initially rates a claimant who is hospitalized. As noted earlier, it is not unusual for a physician in a hospital to notify the WCB that a worker is being treated for a potentially compensable condition. These have typically involved very serious cases, including mesotheliomas. In this situation, or if a worker is known to be gravely ill at the time an initial rating is made, a temporary total disability award is commonly made. Should the worker's condition improve and then stabilize, the employee will be evaluated for purposes of setting a pension.

Prior to January 1, 1974, a worker was not eligible to collect partial disability benefits for asbestos-related disease (primarily asbestosis) so long as the person remained in an occupation where there was a continuing exposure to the hazard. Since then, due to changes in the statute, the employee need not meet this qualification to receive benefits. Where a worker with asbestosis does move, either within the firm or from it, to a less hazardous environment, the worker may face a drop in earnings. If this loss is shown to be due to a move for this purpose the WCB may grant temporary partial benefits, designed to replace the actual loss of earnings. Such benefits are not common in asbestos cases as the WCB appears to prefer to evaluate impairment and to give a permanent disability pension. The temporary partial benefit may be especially useful, however, where the impairment is not (yet) compensable; for example, the person is judged to be pre-asbestotic but a move to a less hazardous environment is highly desirable. Few temporary partial awards have been made for asbestosis. The basis of the award is set at 75 percent of the <u>difference</u> between the previous earnings level and the current one.

Unlike temporary or permanent disability cases, successful claims by survivors are not related to the worker's previous level of earnings. Instead, death benefits are a flat sum paid to the survivor each month, along with allowances for any other dependants. There are at least two highly significant problems in cases involving death among claimants with asbestos disease that may be less common in other types of claims. First, section 43(7) of the law (R.S.O. 1980, c.539)* creates what amounts to an irrebuttable presumption in favor of the survivor where the worker is permanently and totally disabled by a compensable illness or injury prior to death. Thus, a survivor is automatically entitled to compensation where a 100 percent permanent impairment exists before the worker dies, regardless of the cause of death. By contrast the survivor of a worker who is judged to be almost equally disabled from asbestosis (e.g., 90 percent) and who dies in an automobile accident, will not be able to collect any compensation. Again, this practice follows from the statute and is not a policy of the Board.

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* Previously R.S.O. 1970, c.505, s.42(7); as amended by S.O. 1974, c.70, s.3.

Where a worker is disabled less than 100 percent by asbestosis the WCB can award survivors benefits [see s.36(1) of the statute], but the automatic presumption does not exist. Thus, a judgement needs to be made by the medical staff regarding the cause of death. This decision is almost always made by Dr. Stewart or Dr. Dyer without involvement or recommendations from the ACOCD. For understandable reasons, the matter has proven highly controversial in specific claims. On the one side the Board physicians are asked simply to identify whether the death was caused by the industrial disease. On the dependant's side it is difficult to accept that the death was not at least partially caused by a disease that was serious enough to be found pensionable at some earlier time by the WCB. Beyond this, it is not surprising that some survivors apparently believe that the worker's condition was aggravated by a (compensable) disabling, pre-existing condition. The issue is particularly problematic where the worker has a pulmonary impairment and dies from a subsequent cardiovascular condition. The question of causality arises only where the worker was not regarded as 100 percent disabled by the WCB. It also means that workers and their dependants become aware of how important the permanent disability rating is and how

significant (for the survivor especially) the difference is between a 70 or 80 percent award and the 100 percent award.

The second issue focuses on the procedures employed by the WCB when a permanently disabled asbestotic dies. The Medical Services Division is notified that a pensioner with less than 100 percent impairment has died. A death certificate is obtained, along with pertinent hospital records in some instances. (In the files that I read I frequently found a disturbing disparity in the stated cause of death between the death certificate and the Registrar General's form which customarily appear side by side in the file. The Board doctors appear to have noticed this also.) Such records may be of little use or not exist where the worker was not hospitalized shortly before the death. Aside from that, death certificates often contain inadequate or incorrect information on the matter of causality. Evidence exists that this is certainly a problem for persons with asbestos-related disease. The matter is made more difficult by the declining probability of autopsy in Ontario. The Board physicians reported to me that only 25 percent of deaths in the province currently involve autopsy, compared to higher levels in earlier years.

There are at least three significant questions raised by the handling of death in asbestos cases. First, does the WCB receive adequate information regarding the circumstances surrounding a death? The question could as easily be asked of any compensation agency in the world that must make a determination of causality. Clearly, in certain instances this information cannot be obtained. The WCB has made significant efforts, however, and used pathologists when it could to determine the cause of death. Do any alternatives exist?

Second, how has the WCB, and the Medical Services Division particularly, dealt with claimants who had an asbestotic condition but died from a disease other than asbestosis or one of the cancers associated with asbestos? I am not in a position to second-guess the medical judgements made; I can report, however, that the concept of aggravation rarely seems to be employed in such decisions. For example, where a hypothetical person is evaluated as 50 percent disabled from asbestosis and subsequently dies from a coronary condition, it is likely that there would not be a survivors benefit. To many this will seem a harsh judgement, because of the uncertainties regarding any linkage between the diseases. In at

least two instances, however, a cause of death in asbestotics was diagnosed as cor pulmonale and, as such, were compensated.

Data are available on the experience where individuals with asbestosis only (persons with mesotheliomas and other asbestos-related cancers were excluded from consideration) died while receiving workers' compensation pensions. According to the Board's records, in 51 cases the survivor was given death benefits. In sixteen other cases, no benefits were paid to the survivor. In Table 1, the year of death, the last disability rating for asbestosis, and the cause of death on record by the WCB in these sixteen cases are indicated.

The third question is entirely procedural. Many of the deaths that may be due to asbestos-related illnesses are brought to the WCB by survivors or others who seek compensation for dependants. In every sense these are "death claims" and are dealt with accordingly. If a decision is made that the claim is not compensable the applicant is so notified and advised of the right to appeal. The reason for the denial is made known and the survivor is able to consider whether the claim should be dropped or

Table 1

Death Claims Rejected Where Pension Granted for Asbestosis

Year of Death	Latest Pension Rating	Cause of Death
1972	10 percent	Bronchial pneumonia
1973	25	Myocardial infarction
1974	30	Bronchial pneumonia
1975	50	Prostate cancer
1976	40	Multiple (incl. Cardiac-Pulmonary failure)
1978	20	Coronary occlusion
1978	50	Intestinal gangrene
1979	20	Myocardial infarction
1979	Medical Assistance only	Intestinal obstruction
1979	75 percent	Intestinal obstruction
1980	20	Gross malnutrition
1980	40	Cerebral infarction
1980*	50	Cardiac arrest
1980	20	Adrenal cancer
1980	50	Anemia, Prostate cancer
1981*	40	Not available

* Claim outstanding, probably on appeal

continued. This situation is in marked contrast to that where a person with an existing pension for asbestosis dies. The worker's pension is terminated but the WCB automatically considers the question of a survivors benefit. No application need be made by a survivor. The problem that arises is that the survivors are not aware that a very important economic decision about their future is under consideration by the WCB. They will not be able, in routine cases, to bring evidence to the WCB that may shed added light on the cause of death. Possibly more important, since they are unaware that a decision has been made by the Medical Services Division, they are not advised of a right to appeal when the decision is adverse to them. Well-advised or informed survivors may enquire as to their rights after a pensioner has died and thereby learn of the nature of the decision and their right to appeal. But this degree of initiative seems to be the exception. Instead, a decision is quietly made within the Medical Services Division and the case is closed without the potential recipient knowing what was at stake in the decision.

Some of the problems noted above would be dealt with by using the approach found in British

Columbia. Under section 6(11) of its statute (The Workers' Compensation Act, R.S.B.C. 1979, c.437), the WCB of that province must conclusively presume that the death of a worker with an industrial disease "that impairs the capacity or function" of the lungs is the result of that disease where death is caused by an ailment of the heart or lungs. The presumption is limited, however, to non-traumatic causes and the worker must have died prior to the age of 70. Such an approach would minimize some of the very difficult decisions that the WCB will have to make regarding causality in the future. There are a variety of ways in which a scheme similar to British Columbia's might be implemented. For example, the law could allow the benefits to be linked to the size of the pension or the disability rating prior to the worker's death. This would not be consistent with the present scheme which provides for an equal, flat payment to survivors. It might be argued, however, that the higher the partial disability rating prior to death, the more justified is the use of a presumptive guideline and the linkage to the size of the dependant's benefit.

Many other variants on such a changeover are possible. The age limit is set at 70 in British

Columbia for this guideline to be applied. It could be raised or lowered in Ontario. Clearly, the basis for such a cutoff would be its consistency with the balance of the law, that is, in cases not involving industrial diseases. The British Columbia approach might also be broadened or narrowed, if the overall principle would be accepted in Ontario, in terms of the diseases that would trigger the presumption. For example, instead of stipulating that only diseases of the lungs or heart shall do so, perhaps any cardio-vascular cause of death could bring about compensation for the dependants of an asbestotic worker.

A somewhat different scheme might involve providing a death benefit based on the size of the partial disability award. Such a change would mean that the cause of death would be irrelevant in these cases. Its justification would be that determinations of causality are difficult or almost impossible to make, due to medical uncertainties and the quality of the information that the WCB must rely upon in some cases. It would also do away with the all or nothing approach that the current law creates with the 100 percent rating leading automatically to

dependant's benefits but not in the case of the 90 percent rating. A drawback of this type of change is that it would be worse for some survivors than the current approach, for example, if a worker with a low rating for asbestosis dies from a condition that clearly arose out of, and in the course of, employment (e.g., a mesothelioma).

The earnings basis for persons who are no longer employed in an asbestos environment but who develop a compensable industrial disease is a complicated issue that faces any jurisdiction with a workers' compensation law. There are a very large number of variations in how such a matter can be handled. Normally, the earnings basis for a partial disability award is the earnings in the year prior to the date of diagnosis. Where there is no continuing exposure, however, as in the case of retirees, the basis for calculating the size of the pension is that "...comparable earnings of those of a worker working for the same employer doing the same job are obtained for the year immediately prior to the date of diagnosis."* It is not difficult to imagine that

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* See Ontario Workmen's Compensation Board, Written submission to the Royal Commission on Asbestos, #69, June 1981, Sec. 9.1, p.8.

such a formula or almost any other could involve some difficulties. For example, what if the job or the employer no longer exists?

A reading of the claims files leads to two rather clear conclusions in such cases. First, the WCB asks the relevant employer what the appropriate prior year wages are and then accepts the estimate at face value. There appears to be no check on the integrity of this report by the employer. In the more routine partial disability claim the worker serves as a check on this because he actually knows what his previous year's gross earnings from work were. Where the "comparable earnings" approach is used, however, this check does not exist. Neither the worker nor the WCB has a sound basis for evaluating the employer's report.

The second conclusion is that the system has worked well, judged solely on the basis of complaints or appeals revealed in the files. No complaints were raised about this in any interviews of persons concerned with WCB practices. Perhaps the system functions well despite the absence of checks. Possibly it is the experience of the claims adjudicator, gained from working with comparable types of

workers and employers, that assures that a realistic estimate of "comparable earnings" is the basis for setting permanent disability awards.

Pensions for permanent disability awards, either for asbestosis or for any other illnesses or injuries, are based currently on two variables, though a third may be used. The formula for the monthly pension is set by: I x E x .75/12, where I is the impairment rating and E is the earnings basis. For example, if a worker with a $16,000 annual earnings basis (E) is found to be 20 percent impaired (I), his pension would be set at $200/month, tax free. For workers whose permanent disability pension was set in previous years, some periodic adjustments for inflation have been made in the statute. [See sections 42(8),(9),(10) of R.S.O. 1970, c.505., as amended.]

The third variable is based on section 43(5) of the 1980 revised statute* and appears to be used very rarely in cases of asbestos-related disease. The section allows the WCB to supplement the pension "...where the impairment of

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* Previously S.42(5), which was enacted in its present language in 1975; see S.O. 1975, c.47.

earnings capacity of the employee is significantly greater than is usual for the nature and degree of his injury...." The supplement cannot be set to have the total exceed 75 percent of the worker's earnings basis.

At first glance section 43(5) would appear to relieve the WCB of one of the most difficult and emotional issues that has confronted it. Where a worker may be found to be partially disabled from asbestosis, and where in conjunction with other health problems the worker is effectively totally disabled, an impairment rating of only 10 or 20 percent, for example, appears tight-fisted and niggardly. When this strict impairment rating based solely on the asbestos-related condition is juxtaposed with the worker's total disability, the resultant publicity has understandably generated considerable anger towards the WCB. Why has the WCB not made greater use of section 43(5) in such cases and avoided the criticism it has received? The reason appears to be that a significant qualification for eligibility exists such that the pensioner "...co-operates in and is available for a medical or vocational rehabilitation program which would in the opinion of the Board aid in getting him back to work,

or accepts or is available for employment which is available and which in the opinion of the Board is suitable for his capabilities." Clearly, the language of this qualification [of s.43(5)] leaves little room for the WCB to act in the hypothetical situation described above. Indeed, the more serious the person's condition, and therefore the more unreasonable the rating appears, the less likely it is that the person can "co-operate" or that rehabilitation will assist his recovery and return to employment. Under those circumstances, there is a Catch-22 situation and the WCB cannot justify a supplement. Overall, I found that this provision is rarely employed in asbestos cases.

As noted earlier, benefits under Workmen's Compensation have been periodically adjusted for inflation. For temporary total disabilities, the adjustment for inflation need only be made in the statutory maximum. In permanent disability awards, pensions based on earlier determinations are legislatively raised by some common proportion. Awards for future claims reflect inflation through an increase in the ceiling on covered earnings, and as wages are moved up along with other prices and costs. In one area at least that does involve asbestos

disease, inflation has created problems that the law has seemingly neglected. This is the problem of employees who are moved from one employment to another so as to reduce or eliminate their continuing exposure to asbestos.

Suppose that two workers A and B are working in an environment that assures they will continue to be exposed to asbestos. Both are informed that recent changes on their X-rays are suggestive of early but non-disabling asbestosis. Both are advised to change jobs. Worker A does, while B remains in the exposed employment. Prior to his departure A earned $300/week, as did B, but in his new position A earns only $200. Assuming all matters are uncomplicated, A is entitled to a temporary partial award of 75 percent of his lost earnings of $100 or $75/week. Thus, the price paid by A for avoiding continuing exposure is $25/week or a loss of 8.5 percent (the tax consequences do not jeopardize this argument).

After one year both workers earn a 10 percent increase in wages. Worker B now earns $330/week, the level that A would have received had he remained in the hazardous exposure. If A receives

a 10 percent increase also, his wage is now $220 and his temporary partial compensation benefit is .75 ($300-220) or $60. Thus, his gross earnings increase by $5 to $280 but the critical gap between his present earnings and those foregone is $50/week or about 15.1 percent below B's earnings. The problem of course is that the earnings loss on which the benefit is based has not moved from $300 despite the fact that inflation and productivity growth make that figure less relevant to the worker, economically, with the passage of time. While it may appear that the issue is one of fairness, this is not the foremost consideration. Instead, it is that this approach must undermine the intended outcome of encouraging workers to move from exposed environments when disease begins to be manifested. The desirability of this sort of assistance is discussed in Chapter VIII of this study.

Benefits for asbestos-related diseases are paid by the WCB. Costs for such claims are charged back to the last employer where the worker had been exposed to asbestos. This procedure is followed even where the worker may have been exposed in many establishments and might even have been employed longer at one of those than with the last employer. In some

instances, the WCB has found that this blanket-type policy has led to an inequity and has instead applied the claim's cost to all employers in that industry classification.*

The Second Injury and Enhancement Fund (SIEF) is a mechanism used by the WCB to have employers hire or retain employees with some type of pre-existing impairment. Actually, the SIEF is less to encourage, than it is to have workers' compensation not discourage, these employment practices. Most jurisdictions use some technique or other akin to the SIEF.

It would not be sound public policy to use the SIEF in the case of asbestos-related diseases and, indeed, the WCB does not do so. It is probably not desirable to provide any incentive to employers who may expose their employees to asbestos to hire workers with such illnesses. Other employers are not likely to be harmed economically if asbestos-related disease creates or exacerbates a compensable disability, since only the last employer where asbestos was

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* See, for example, Ontario Workmen's Compensation Board. Claims Division, Claims Adjudication Branch. Procedures Manual (Toronto: Ministry of Government Services), Document #33-02-01.

encountered will be charged or penalized. The non-asbestos using employer needs no removal of the disincentive to hire such workers.

A. British Columbia and Quebec

An alternative approach to the provision of benefits exists in Quebec which employs a modified wage-loss scheme. This system currently applies only to claims arising from mining or work in quarries but recent legislative changes apply this approach to all workers with asbestos-related diseases. Three physicians examine a claimant and if they believe asbestosis exists, they assess the extent of impairment. A lump-sum award is made on the basis of this and a consideration of the worker's age. Thereafter, compensation is based on the estimate of earnings loss incurred by the worker. In Quebec this is particularly significant as such persons lose their licence to work in the mines or quarries where asbestos exists. The formula for replacing lost earnings is based on 90 percent of the net wage loss.

In the manufacturing and services sectors, compensation for asbestosis is based on the impairment rating and is broadly similar to Ontario's

approach. Eventually, these disparate methods will be reconciled and uniformity will occur by extending the current approach in the mines to all other sectors. The employee currently is not subject to removal from continued exposure to asbestos in these sectors.

The modified wage loss approach for asbestosis from mining or quarrying in Quebec differs very significantly in another respect from Ontario's. Unlike the payment of a permanent pension as is found in Ontario, Quebec begins to reduce the wage loss benefit when workers reach age 65 and by age 68 these benefits have been eliminated. Claimants who develop asbestosis at age 70, for example, are entitled only to a lump-sum payment, the maximum -- at that age -- being $8,745 where there is 100 percent permanent disability.

The approach to determining benefits for compensation of asbestos-related diseases in British Columbia is much more similar to Ontario's than is Quebec's. A worker's compensation for permanently disabling asbestosis is based on the extent of physical impairment and is set by multiplying this rating by 75 percent of the gross earnings base.

Certain disparities do exist. One difference between British Columbia and Ontario is that the maximum benefit or earnings ceiling is 19 percent higher in British Columbia. Secondly, in about 5 percent of the cases in British Columbia the pensions have been increased where the worker has had a significant earnings loss. Thirdly, the earnings basis for a retired applicant for a permanent disability award is the worker's last actual wage during exposure and not the estimate of what a comparable worker is now actually earning, as in Ontario. Many of the asbestosis pensioners have been hurt by inflation and their earnings base is set at the minimum level that the province has stipulated. Finally,both British Columbia and Quebec base the survivors pension on the worker's level of earnings, unlike the flat amount used by Ontario. (A flat amount is used in British Columbia where the widow is under the age of 40, is not an invalid, and has no dependant children.)

Chapter IV Advisory Committee on Occupational Chest Diseases

If a claim is made for asbestosis, the most important decisions regarding it are made by persons who are not staff or members of the WCB. Instead, the two crucial decisions -- whether or not the claim is compensable and at what level, if any, to rate it -- are made by the Advisory Committee on Occupational Chest Diseases. These two determinations are virtually never changed by staff or members of the WCB.

In 1929 the WCB created the Silicosis Referee Board to assist it in the diagnosis and evaluation of claims for silicosis. Members of the Board were physicians employed by the Division of Industrial Hygiene, which was at that time located in the Ministry of Health (then called the "Department" of Health). The WCB also appointed consultants to the Silicosis Referee Board, and these came from staff of the University of Toronto. This panel proved to be very durable with all the original appointees serving until 1961 when they were replaced.

The new appointees were all full-time staff of the Ministry of Health.

Since 1961 there has been relatively little turnover although the panel has not retained the absolute stability of the years between 1929 and 1961. It consists of five members, the chairman having been on the panel since 1961. All five members have at one time been or currently are employees of the Ministry of Labour or of Health. In addition to the five members there are three consultants who meet with the panel. Two are senior physicians at Toronto General Hospital who hold appointments as faculty -- in medicine or pathology -- at the University of Toronto. The third consultant is Director of the Occupational Health Programme, McMaster University Medical Centre. Two of the three are considered members of the group, while the third, the pathologist, works closely with it.

In 1970, the body's name was changed to the Advisory Committee on Occupational Chest Diseases (ACOCD) to reflect better its actual function. For example, the panel had been involved, not simply with

silicosis, but with all the occupational pneumoconioses for some time -- the WCB accepted its first asbestosis claim in 1948.

As noted in Chapter II, the decision that a claim be evaluated by the ACOCD is made by a Board doctor, typically Dr. Stewart or in some instances by Dr. Dyer, chest diseases medical specialists for the WCB. It is important to realize that the ACOCD is not used to make decisions exclusively in claims that are thought of as difficult. Instead, the WCB's procedures require that all claims for asbestosis be seen by the ACOCD where some preliminary evaluation by medical staff suggests that compensation is possible.

That WCB procedures require that the views of the claimant's doctor not be accepted on their face when they favour a claim is not surprising. The WCB acknowledges that such decisions are technically difficult, and that some physicians may err due to their inexperience in such cases. Yet, this same lack of experience could cause a private physician to incorrectly conclude that a patient does not have asbestosis, and that judgement may cause a claim to be rejected without a review by the ACOCD. In some

instances, this decision is made by the Board doctor after he reviews the chest X-rays of the claimant.

A claimant typically is examined by a member of the ACOCD at a pulmonary function laboratory that is not located at the Board's offices. The physician who examines the claimant reports his findings to the ACOCD which then evaluates the claim. The Committee does not keep minutes of its meetings, nor are its votes recorded. A majority vote leads to a recommendation that is sent to Dr. Stewart, though officially the recommendation is made to the WCB. There is no indication in such memoranda that a difference of views existed. It is impossible to judge whether the single position that ultimately surfaces reflects a compromise between or among different views or whether it is a polar position held by a majority of those voting.

The Committee members are expected to attend all meetings of the ACOCD and to see claimants and occasionally travel to other cities to examine them. By contrast, the consultants may limit their involvement somewhat. They are not expected to attend all meetings, particularly if only routine or simple issues are to be heard. Members of the ACOCD receive small honoraria for their services.

The process of replacing a member of the ACOCD is somewhat vague. Should a current member resign, it is likely that his replacement would come from the same agency where the retiring member is principally employed. It is probable that the replacement would have attended some earlier meetings of the ACOCD and observed its procedures. To replace a retiring member the ACOCD would suggest a name to the WCB, with the latter having the right to reject the recommendation. The process, however, is handled somewhat informally.

The ACOCD is entirely removed from the day-to-day workings of the WCB. The members are not necessarily familiar with Board procedures. Moreover, the ACOCD is not informed of the outcome of a claim. In the overwhelming majority of cases (involving asbestos) the ACOCD makes a determination of diagnosis, etiology and extent of impairment. The latter is largely a medical (or physiological) matter, although not entirely since some other information may emerge in the course of interviewing the worker that influences an estimate. Basically, however, the ACOCD decides how impaired (as distinct from disabled) the worker is and notifies the WCB through Dr. Stewart. The WCB almost never modifies this judgement.

The ACOCD will customarily include in its recommendation to the WCB that a worker be rescheduled for a future examination by it. Where impairment is found the ACOCD usually will want to review the worker's condition in a year. In very serious cases, the ACOCD may wish to re-assess the condition in six months or so. Where a claim is found to be not compensable, a person's condition may warrant continuing review, perhaps one or even two years in the future. Some quantitative evidence on the frequency of re-examination is presented in Chapter VI of this study.

Chapter V Guidelines

A. Introduction

Both in theory and in practice the WCB is able to compensate any industrial disease resulting in disability. Under section 1 (1)(n) [previously s.1(1)(l)], the statute indicates "'industrial disease' means any of the diseases mentioned in Schedule 3, and any other disease peculiar to or characteristic of a particular industrial process, trade or occupation;" Schedule 3 is a list of diseases which the Board is to presume are peculiar to or characteristic of some specified process, trade or occupation. Section 122(9) of the 1980 statute* creates a strong presumption for a disease listed in Schedule 3 that assists the employee in pursuing this claim before the WCB. The presence of the disease and evidence showing that the employee has been in the process, trade or occupation identified in Schedule 3 make it almost automatic that the claim will be judged a (compensable) industrial disease.

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* Previously R.S.O. 1970, c.505, s.118(8); as amended by S.O. 1973, c.173.

Asbestos does not appear in Schedule 3, nor do any diseases thought to be especially linked to it, such as mesotheliomas or asbestosis. Instead, item 8 on the list is simply "the pneumoconioses other than silicosis." Nothing appears under the "process" column in item 8, however, leaving the WCB with great flexibility -- but no statutory guidance -- in the matter of such illnesses.

The absence of more explicit guidance in Schedule 3 has meant that the WCB has been left with two basic approaches to resolving claims for asbestos-related pneumoconiosis or other asbestos-related diseases. It can approach each claim as if it were entirely new. Historically, this has been the WCB's approach when very few claims for a specific disease had materialized or were expected. When several claims for a disease begin to develop, however, the WCB may choose to adopt a policy whereby it will accept or reject any such claims as industrial diseases, subject to certain facts of the individual circumstances. The setting of such policy allows the WCB to render consistent or equal treatment to broadly similar types of claims. It also permits the WCB to communicate widely that a specific disease under certain circumstances is regarded as an

industrial disease. The policy essentially does what Schedule 3 does and eliminates the need to amend the statute by adding to or modifying this list.

According to one history of the WCB,* cancer was first considered as a potentially compensable disease by amendment of the statute (and Schedule 3) in 1932. An amendment of the law in 1947 gave the WCB the right to designate diseases as "peculiar to or characteristic of..." by regulation. The adoption of a guideline serves to so designate a specific disease, under whatever circumstances the WCB believes are warranted.

In determining such a policy the WCB may choose to be rather explicit as to the circumstances that could limit its acceptance of a claim. There are actually two distinct decisions that the WCB may make in terms of an unlisted or vaguely specified disease. The first is that the WCB will accept certain types of illnesses or conditions as an industrial disease, thus establishing a presumption that strengthens a worker's claim. The second decision that may be made is to identify specific

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* D.W. Dyer, "Occupational Cancer," Mimeographed, (n.p., n.d.), p.1.

circumstances under which the WCB is more likely to accept or reject a claim. It is this second process, the formulation and use of guidelines, that is described below.

B. Asbestos Guidelines

In 1981, five guidelines were in place to deal with claims for asbestos-related disease. These involved asbestosis, asbestos fibre dust effect, the mesotheliomas (i.e., pleural and peritoneal), lung cancer, laryngeal cancer, and gastro-intestinal cancers. It should be noted that these guidelines followed the development of others not related to asbestos, the earliest of which involved coal tar as a carcinogen in 1949 (see Table 2). After a 1956 study by the Division of Industrial Hygiene (then in the Ministry of Health), guidelines were developed in connection with pulmonary cancer in workers exposed to arsenic or cobalt dust at Deloro Smelting and Refining Company. In 1961 the WCB adopted guidelines for compensating employees at International Nickel Company who developed nasal sinus or lung cancers. The same diseases were included in guidelines adopted in 1972 for employees in the sinter plant at the Copper Cliff smelter.

Table 2

Workmen's Compensation Board Guidelines - Occupational Diseases

	Disease	Process or Hazard	Year
1.	Lung Cancer	Coal Tar	1949
2.	Lung Cancer	Arsenic-Smelting	1956
3.	Lung and Sinus Cancers	Nickel Refining	1959
4.	Lung and Sinus Cancers	Sintering	1969
5.	Lung Cancer	Uranium Mining	1976
6.	Lung Cancer	Asbestos	1976
7.	Mesotheliomas	Asbestos	1976
8.	Lung Cancer	Coke Ovens	1976
9.	Gastro-intestinal Cancer	Asbestos	1976
10.	Asbestos Fibre Dust Effect	Asbestos	1976
11.	White Finger Disease	Vibration	1978
12.	Laryngeal Cancer	Asbestos and Nickel Aerosol	1978
13.	Emphysema - Antitrypsin Deficiency	Dusts or Fumes	1979
14.	Chronic Obstructive Lung Disease	Sulphur Dioxide - Smelting	1979
15.	Lung Cancer	Foundry	1979

Note that in each of those early guidelines, the range of coverage was immediately limited to a single firm.

B.1 Asbestosis - It is arguable whether or not guidelines exist in the case of asbestosis. While the WCB has adopted certain "procedural guidelines" in claims involving asbestosis, there are only two requirements for the claimant to meet. First, there needs to be "a clear and adequate history of occupational exposure to asbestos." Second, there must be "a diagnosis of frank asbestosis." The procedures yield no clue as to the meaning, if an absolute one exists, of the phrase "clear and adequate history." The burden of judgement appears to rest on the third requirement of the guideline, that an advisory committee examines the case and renders a decision. Other than these first two elements noted, no guideline is provided to the advisory committee.

B.2 Asbestos Fibre Dust Effect - On May 11, 1976, the WCB approved a special rehabilitation programme for workers suffering from either asbestosis or a pre-asbestotic condition called asbestos

fibre dust effect. In conjunction with this effort the WCB issued medical guidelines to help identify those workers eligible for benefits and services under the programme. The WCB approved the following criteria as the means of making this determination:

a) An adequate history of exposure is documented -- minimum of 10 years unless an unusual intensity exposure is established.

b) When at least two of the following radiological signs are present: (i) intralobar pleural thickening (major or minor fissures); (ii) variable obliteration of the costophrenic angles; (iii) variable pleural thickening of a focal or plaquelike nature along the lateral chest wall or diaphragm is noted.

c) And when in addition at least two of the further following radiological signs are present: (i) horizontal linear markings 1.3 mm. thickness in the lower zones usually bilateral; (ii) a general coarsening of the lower zone linear pattern with partial replacement by a reticular or net-like pattern; (iii) superimposed of minute bead-like opacities, 1-2 mm. in diameter over or adjacent to the lower zone pulmonary arterial tree.

d) These changes described above must have occurred during the preceding five- to ten-year period.

e) The vital capacity studies may have shown changes over the past 5 years although the last result is still within normal limits.

The guidelines for evaluating eligibility for an entitlement for AFDE are very finely detailed and bear no essential relationship to the guidelines for asbestosis. In Chapter VIII of this study the nature of a special rehabilitation programme that is linked to the concept of AFDE is described in some detail. The possible reasons for the highly detailed guidelines are discussed there.

B.3 Mesotheliomas - Two forms of this rather rare form of cancer exist and it is widely believed that both are caused by exposure to asbestos. Estimates vary on the extent to which asbestos has been linked to primary mesothelioma tumours, but there seems to be little doubt that its role as the causal agent is extremely significant. The guidelines adopted in 1976, and in effect presently, identify three criteria in deciding a claim:

a) There is a clear and adequate history of at least 10 years occupational exposure to asbestos; and

b) There is a minimum interval of 15 years between

first exposure to asbestos and the appearance of mesothelioma.

c) Claims which do not meet the guidelines in (a) and (b) should be individually judged on their own merit having regard to the intensity of exposure and other factors peculiar to the individual case. Consideration will be given where it seems evident that the mesothelioma cancer resulted from occupational exposure to asbestos. The benefit of reasonable doubt applies.

B.4 Lung Cancer - In April 1976, at the same time that the WCB accepted the guidelines for mesotheliomas, it adopted the following guidelines for lung cancer in workers exposed to asbestos:

a) There is a clear and adequate history of at least 10 years occupational exposure to asbestos, and

b) There is a minimum interval of 10 years between first exposure to asbestos and the appearance of lung cancer.

c) Claims which do not meet the guidelines in (a) and (b) should be individually judged on their own merit having regard to the intensity of exposure and other factors peculiar to the individual case. The benefit of reasonable doubt applies.

B.5 Gastro-Intestinal Cancer - These guidelines were adopted by the WCB in October 1976 and apply to primary tumours that develop in the esophagus, stomach, small bowel, colon and rectum. They call for favourable consideration of a claim where the following conditions exist:

a) There is a clear and adequate history of exposure to asbestos. This is not defined quantitatively but the guideline calls for the workplace exposure to be "of a continuous and repetitive nature and should represent or be a manifestation of the major component of the occupational activity."

b) There is a minimum latency period since first exposure of 20 years.

c) That no distinction be given to the site of the cancer in assessing the claim's merits.

d) Claims that do not meet the above guidelines are to be judged on their merit, and in consideration of the applicant's occupation, extent of exposure and other individual factors.

Again, as in the guidelines for the mesotheliomas, the somewhat puzzling language appears, "Consideration will be given where it seems evident that the gastro-intestinal cancer resulted from

occupational exposure to asbestos." The benefit of reasonable doubt applies, presumably in the favour of the applicant.

B.6 Laryngeal Cancer - The last guidelines for asbestos-related disease were approved in May of 1978 by the WCB. The guidelines were prepared in conjunction with those dealing with nickel aerosols and some parts refer to a situation where a worker is exposed to both hazards. Claims for cancer of the larynx are to be favourably considered where the following criteria are met:

a) The exposure to asbestos at the workplace "should be of continuous and repetitive nature and should represent or be a manifestation of the major component of the occupational activity."

b) There should be a cumulative minimum proven exposure of 10 years. If there is a dual exposure to asbestos and nickel the period of needed exposure to asbestos is 5 years.

c) There is a minimum latency period from first exposure to asbestos of 20 years. Where there is a dual asbestos-nickel exposure, the latency period drops to 15 years.

d) Where a claim does not meet the guidelines, it is to be judged on its merits "having regard to the intensity of exposure and other factors peculiar to the individual case."

C. Development of the Guidelines

Since the guidelines have the potential for sorting claims into those that will be successful or not, the procedures whereby they are developed become important. There appear to be no explicit rules that formalize this process. In order to better understand how the process has operated in the past, I shall focus on the development of the guidelines for lung cancer, mesotheliomas, gastro-intestinal and laryngeal cancers.

At the time when asbestos disease claims began to grow and the public's attention was directed to this matter, a subcommittee of the Board's Management Committee was formed to establish guidelines for lung cancer and mesotheliomas in asbestos workers. The subcommittee consisted entirely of staff drawn from the Claims Services Division, the

appeals system and the Medical Services Division. The need for guidelines was prompted by concern regarding the actual and anticipated growth in claims from workers previously exposed to asbestos. In this case and in all other guidelines developed on asbestos, the decision to develop guidelines derives not from some ongoing process or automatic review, but is entirely ad hoc.

The guidelines for the mesotheliomas and lung cancer in these workers were recommended from the subcommittee to the WCB's Management Committee and from there made official by approval of the Corporate Board in April 1976. The specific recommendations that became the guidelines emerged from a study undertaken by a pathologist at the University of Toronto, Dr. A.C. Ritchie, that had been commissioned in 1974. The report was transmitted to Dr. Charles Stewart in March 1975 and led directly to the lung cancer and mesotheliomas guidelines, although Ritchie delivered a supplementary report on April 15, 1976, and a "Report III" on July 27, 1976.

The lung cancer guidelines are far more significant than those for the mesotheliomas since the former appears to be a much more widespread disease in asbestos workers. Moreover, lung cancer is frequently found in the public at large, many of whom have had no special exposure to asbestos. For adjudication purposes this is a more important and controversial standard. A number of issues about the lung cancer standard seem notable. First, Ritchie summarizes the literature by observing, "Carcinoma of the lung is more likely in those heavily exposed to asbestos, but may occur in those only slightly exposed....."(Report I, p.22) Later in that report he concludes, "No easy rule is available to determine the duration and intensity of exposure to asbestos needed to make an asbestos worker eligible for compensation if he develops carcinoma of the lung. All the population of Ontario has been exposed to asbestos and can be assumed to have asbestos in their lungs. Where then should be the point at which occupational exposure is such as to justify compensation? No data exist to indicate the answer to this question. All that can be suggested at this time is that each case be considered separately, and reasonable exposure be accepted." (Report I, pp.28-29)

While Ritchie recommended that no minimum exposure rule be adopted, he did recommend that a 15-year minimum latency period rule be applied, from first exposure to asbestos to onset of disease. Yet, this is somewhat tempered by his subsequent observation that "...some latitude in requiring a 15-year interval from first exposure before allowing compensation for carcinoma of the lung should also be given."(Report I, p.29) In his supplementary report Ritchie again endorses a 15-year minimum latency rule and the principle that there be no quantitative exposure rule, recommending simply that compensation be paid where "there is a history of adequate exposure to asbestos, or clear histological evidence of such exposure."(Report II, p.16) No definition of "adequate" is provided.

A major contributor to the development of all asbestos guidelines has been Dr. Stewart and it is clear that he served as liaison between the subcommittee charged with preparing them and Dr. Ritchie. Following Dr. Ritchie's first report, Dr. Stewart prepared a memorandum indicating his agreement with Ritchie's suggestions: "The definitive study has been done by our Consultant

Pathologist, Dr. Ritchie, and it is clear that he believes there is no formula developed employing duration of exposure and fibre count which has any meaning. I agree with him here because the literature contains no studies comparing various suggested fibre count duration exposure formulae against incidences of asbestosis or lung cancer."

Later in the same memorandum Stewart accepts Ritchie's two-part guidelines, that is, "a clear history of occupational exposure" and the 15-year minimum latency rule, though he also appears to prefer a shorter latency period without specifying what it might be.

It is surprising to me that Stewart's and Ritchie's recommendations were not adopted by the Management Committee and the Board. Instead, as noted earlier, the guidelines stipulate that there be "...a clear and adequate history of at least 10 years occupational exposure to asbestos." The Board ultimately adopted guidelines considerably more demanding than its own consultants recommended. By contrast, the latency period rule was established at

10 years, less restrictive than Stewart's and Ritchie's views. Further, note that cigarette smoking is not considered as a factor in this or any other of the asbestos guidelines.

Finally, it should be noted that Ritchie recommended an additional guideline that does not appear to have been adopted by the WCB. That it has not been made official policy is not to say that worthy claims have been denied. The recommendation by the pathologist in both his original and supplementary reports was that lung cancer be accepted in any instance where asbestosis was present. This has not been acted upon in the sense that no such guideline has been so written and accepted, but the practice of the WCB appears to be consistent with this view and was so even prior to Ritchie's original report. It is not clear to me why no such formal guideline was issued.

The guidelines on the mesotheliomas were developed at the same time as those for lung cancer. They too resulted from Ritchie's original report and were accepted by the Board at the same time as the

lung cancer standards. While his first report was only suggestive, Ritchie's supplementary report left no doubt about his views: "Mesothelioma can occur in people who have only moderate exposure to asbestos and who show no other evidence of asbestos injury" and "that all with any exposure to asbestos who develop mesothelioma should be compensated." In contrast with this wide open type of guideline the Board adopted a more rigorous and seemingly arguable standard that, "There is a clear and adequate history of at least 10 years occupational exposure to asbestos." The WCB also adopted a 15-year minimum latency period rule which is at odds with Ritchie's recommendations but somewhat consistent with his observation that the disease "rarely develops" until 15 or 20 years or more after first exposure to asbestos.

It is important to note that in the case of the mesotheliomas the WCB has adopted guidelines that rarely if ever are used to deny a claim. The guidelines are far more restrictive than Dr. Ritchie suggested, but the practice of the WCB is to compensate for mesotheliomas wherever an occupational exposure to asbestos can be demonstrated.

That the guidelines for the mesotheliomas may be less than ideal is implied by a request from the Secretary of the Board to the Executive Director of the Medical Services Division asking that the experience with them be assessed. In response the five Board doctors involved with the guidelines unanimously agreed that the existing standards were satisfactory, and that there was no need for change at that time (July 1980). Curiously, their defence of the existing guidelines acknowledged that 23 percent of the allowed claims involving mesotheliomas had exposure durations of under 10 years, but they argued that the mean period of exposure in accepted cases was 19.6 years. Surprisingly, the argument here, and in the defence of the 15 years minimum latency period rule, and in similar matters argued by the medical staff, appears to focus on an inappropriate statistic. Of all measures of central tendency the mean is the least relevant for policy-making purposes since a few very long periods (of exposure or of latency) will cause the average to be increased. Indeed, a more revealing statistic for these purposes is the variance or the standard deviation and not the mean of the distribution. In

this way the WCB could judge what the guidelines ought to have been to allow the WCB to compensate, for example, two-thirds or 98 percent (or some such arbitrary proportion) of the cases that it did end up compensating. Moreover, what seems even more pertinent than the cases accepted, whether or not they were consistent with the guidelines, are those that were not allowed.

The guidelines for gastro-intestinal cancers also began in the work that the Board commissioned from Dr. Ritchie. His conclusions were tentative at best and he recommended that follow-up studies be done, preferably by an epidemiologist. Professor A.B. Miller, Director of the Epidemiological Unit of the National Cancer Institute of Canada, accepted the request of Dr. McCracken to evaluate the literature linking asbestos and gastro-intestinal cancers.

The work prepared for the WCB by these two scientists confronted the Board with a problem. Unlike mesotheliomas or bronchogenic carcinoma the linkage between asbestos and gastro-intestinal

cancers was much weaker. The problem was rooted in the data which showed a considerably smaller risk ratio in the latter than in the case of either lung cancer or the mesotheliomas. The shakiness was evident upon examining the positions taken by Ritchie and by Miller. In his original report Ritchie wrote, "At this time [March 1975] the evidence seems insufficient to justify compensation for an asbestos worker who develops carcinoma of the stomach, colon or larynx, however evidence in this matter is accumulating, and each case should be evaluated in the light of the evidence as it develops." He did not comment upon cancer of the esophagus or rectum.

Ritchie's position changed by April 1976, though the evidence on which he based this was still very weak. He recommended:

> ...that provisionally, and with full realization that our knowledge is incomplete, that revision of these criteria will probably prove necessary within a few years, and that half of those exposed to asbestos who develop carcinoma of the colon or rectum would have developed the cancer even if never exposed to asbestos, all exposed to asbestos who develop carcinoma of the colon or rectum should be compensated if:
> a) there is clear evidence of considerable exposure to asbestos;
> b) not less than 20 years have lapsed since the beginning of exposure.
>
> No clear definition of what is meant by "considerable" in (a) above is possible at this time.

Later in Ritchie's report he recommended precisely the same guidelines for cancers of the esophagus or stomach but acknowledged that the evidence in regard to these diseases was even weaker than for cancer of the colon or rectum. The tentativeness of each of these sets of recommended guidelines is confirmed by his position urging that any decisions be reviewed in the light of new evidence in three years.

Miller's review of the literature, summarized in his September 1976 report to the WCB, led him into broad agreement with Ritchie's later position. Miller concluded that guidelines should be developed linking asbestos, causally, to gastrointestinal cancers at all sites, after a 20-year latency period has passed.

The guidelines that the WCB adopted in October 1976 were broadly consistent with these recommendations though they were also somewhat more restrictive. They were tighter in that they stipulated that the exposure to asbestos "should be of a continuous and repetitive nature and should represent or be a manifestation of the major component of the occupational activity." These added criteria, that

is, "continuous," "repetitive" and "the major component," all represent qualifications that go beyond Ritchie's and Miller's works. They appear to emerge from Dr. Stewart's assessment of the state of knowledge during the period when the guidelines were formed.

The guidelines for laryngeal cancer are the most recent ones adopted by the WCB for asbestos-related disease. They appear to have been the most difficult. The original linkage between asbestos and this disease from the perspective of the WCB came from each of Ritchie's three reports. His work led to retaining Dr. Miller in late 1976. His work for the WCB involved more than the customary literature search, causing him to undertake some independent studies which began in February 1977. Upon the urging of the WCB, Miller prepared a report in April 1978 that he stressed was incomplete and tentative, but that did conclude that asbestos was a cause of laryngeal cancer. He also focused on the synergism of nickel and asbestos as causal agents in this disease. While the ultimate outcome of the guidelines in terms of the latency periods issue sprang from Miller's report, the exposure criterion emerged

only from discussions that Miller had with WCB staff and not from the report itself. This makes it more difficult to evaluate the WCB's action.

The guidelines for laryngeal cancer were prepared with some sense of urgency. They might have been delayed until Miller had prepared a final report had the WCB not felt that public concern dictated the need for such guidelines. At this time, there is no finalized, public version of Miller's report and the WCB has continued to operate for over three years with the guidelines based on the preliminary work by Miller. Though the guidelines are used they are regarded as provisional even now.

D. British Columbia and Quebec

In British Columbia there are three bases for being compensated for an industrial disease. First, a disease and its source may be found in Schedule B of the statute,which is broadly similar to Ontario's Schedule 3. The WCB has the right to modify this list of diseases and processes but needs Cabinet approval to do so. A second approach is that the disease can be covered by the Board in regulations that it develops. This would be analogous to Ontario's guidelines described above. Finally, the

WCB can accept an illness as an industrial disease in any individual claim that it wishes. In this respect, Ontario and British Columbia are very similar.

In considering guidelines or changes in Schedule B, ideas and positions have been submitted in British Columbia by groups outside of the WCB. Further, as the Board prepares to change or add a regulation the views of interested groups such as employers and unions are solicited. As has been noted this has not been the practice in Ontario.

The WCB's approach to asbestos-related disease in British Columbia is found in Schedule B and not in the regulations. This too differentiates it from Ontario. In British Columbia the Schedule is somewhat tougher than the system in Ontario. Specifically, it allows for compensation for lung, laryngeal or pharyngeal cancers only in the presence of asbestosis, or gastro-intestinal cancers where there has been a period of cumulative continuous exposure to asbestos dust of 20 years and the exposure represents a major component of the worker's activity. There are, however, no time or quantitative exposure rules for cancers of the lung, larynx, pharynx, the mesotheliomas or for asbestosis.

In Quebec the Commission is currently compensating lung cancers only in the presence of asbestosis or mesotheliomas. It does not accept cancers of the pharynx, larynx or the gastro-intestinal system (which in British Columbia and Quebec would incorporate the esophagus, stomach, small bowel, colon or rectum). Any future change from this practice would involve creating a guideline that would be developed by the Commission's medical staff and then approved by the fifteen-member Board of Administration. The latter consists of the Commission's President, seven representatives from labour and seven others from industry.

E. Applications of the Guidelines

A variety of questions remain regarding the guidelines for compensating impaired workers with a previous occupational exposure to asbestos. If answers to them can be found they may affect future policy decisions for the WCB.

a) The previous section has pictured the process of developing guidelines for asbestos-related disease as largely an operation that is internal to the WCB. Aside from WCB staff, only two outsiders,

Dr. Ritchie and Dr. Miller, have played any significant role at all in their development. These issues are not without controversy, even in a purely scientific environment that is totally removed from the emotion-filled arena of compensation. How were these experts selected? Given the very prominent role played by Dr. Ritchie, it is necessary to query the choice by the WCB of a pathologist to carry out the original literature search instead of one or more other health science specialists.

However and whomever the WCB chose to study these diseases, it seems striking that so much of the guidelines development involved only WCB personnel. An outcome of this was the prominent role played by the WCB's chest consultant, Dr. Stewart, in the formulation of the guidelines on even gastro-intestinal cancers. This reflected the WCB's continuing practice of depending very heavily on insiders to develop guidelines rather than going outside and seeking a variety of views. This is not to challenge the WCB's authority to decide on appropriate guidelines itself, but rather to question the very closed process that led up to the final decisions.

b) The preparation and application of these guidelines is done with minimal amounts of information provided to the interested parties. It appears that few persons outside the WCB are aware that a new guideline may be under consideration or that one has been promulgated. I enquired on this matter directly and was given somewhat contradictory views by WCB staff. This was no doubt a matter of opinion but, based upon my interviews with interested parties in the province, it does appear that the existence of the guidelines and, more significantly, their substance, are not widely known. This ignorance also extends to the manner in which the guidelines are being developed, the role of outsiders in their formulation and changes under review.

The WCB may perceive some difficulty in identifying capable and objective scientists to help in preparing guidelines. If that be the case one might consider the absence of any role given to its own Advisory Committee on Occupational Chest Diseases. While any such role would be a departure from the Committee's present function, it would not appear to present any obvious problem for either the WCB or the Committee.

c) The first set of guidelines for asbestos-related cancers was adopted by the WCB in 1976. A Board doctor has since written of the guidelines, "These are based on constant review of the world medical literature, cases submitted to the Board, studies of the details of exposure, and epidemiological studies in various industries."*

It appears clear that such a review is informal only. No specific reconsideration of existing asbestos guidelines is in place. Moreover, each asbestos guideline has been left intact since its original promulgation. This may be evidence of the skills manifested in the original guidelines. It may also attest to a reluctance to evaluate and to change a formula once it has been developed.

d) The evidence in Section C of this chapter demonstrates that the WCB has been willing to modify or reject some of the recommendations of its outside research experts. The Board's authority to do so cannot be challenged. The considerable willingness of the WCB to do so, however, suggests that the role of inside people at the WCB is even more significant than the process alone would suggest.

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* D.W. Dyer, "Occupational Cancer," Mimeographed, (n.p., n.d.), p.3.

e) There is no system that initiates the consideration or development of new guidelines and the situation is ad hoc. Political interest in certain types of cases is said to be one of the factors that sets the process in motion. Almost certainly what triggers the process in most cases is the perception that a problem exists, more than likely a series of difficult or unpopular decisions by the medical staff.

f) The process of developing guidelines is not a rapid one. No doubt, hastily developed standards would earn the WCB considerable criticism. Haste could lead to some serious errors. But the speed with which the Board has moved is significant in a different context. When I asked some Board staff about the possible advantages and disadvantages of opening up the guideline-setting procedure, the major criticism of so doing was that it would slow down the workings of the system. It seems clear, however, that the system has moved with understandable caution until now. It is not evident that wider use of outside experts would (considerably) delay the process in the future.

g) It is clear that the WCB considers the guidelines to be important, both as a statement of

policy and as a carefully considered yardstick in evaluating specific claims. Where guidelines exist the WCB has very clearly sought to use them as a screen for claims. It has customarily allowed claims that met the guidelines, seldom if ever rejecting any that met the letter of the rules. By contrast, the WCB often allows claims that do not meet the criteria of the guidelines.

The general situation is that the guidelines create virtually an irrebuttable presumption by a claimant who meets the specified conditions. Where a claimant does not meet these criteria there still remains a substantial possibility that compensation will be paid. The guidelines are handled with an asymmetric flexibility and one might ask if guidelines are actually needed where the system is so flexible. The answer would appear to be yes. The guidelines create a mechanism whereby the WCB can deal with unresolved medical issues in a policy setting. In setting guidelines, decisions are made at several levels of the WCB up to the top of the agency. Further, it identifies those conditions that will regularly cause compensation to be paid. This

generates some elements of consistency in the decisions coming from the WCB, where the cases are potentially difficult to sort out, particularly on matters of etiology.

Chapter VI Quantitative Experience

The subject of industrial disease has captured considerable public attention during the 1970's and early part of the 1980's. In most jurisdictions in North America and Western Europe these illnesses have represented a very small portion of the workload for compensation agencies, at least judging by claim volume. Focusing solely on allowed claims in Ontario (because of data availability) from 1974 to 1980, industrial diseases were annually in the range of 1.1 percent to 1.9 percent of all claims compensated by the WCB, very much in line with the experience of other jurisdictions. Data on allowed claims are shown in Table 3.

The upward movement in this proportion from 1974 to 1977 appears to have levelled off. Much of the growth in disease cases over this time has been in relatively non-serious cases and in successful hearing loss claims. Claims for cancer, which include the mesotheliomas, have risen substantially on a proportional basis but remain a trivial fraction

Table 3

Allowed Claims

Year	All Claims	Industrial Disease Claims	All Fatal Claims	All Cancer Claims	All Fatal Industrial Disease Claims	All Fatal Cancer Claims
1980	411,476	7,611	324	64	94	42
1979	413,008	7,829	323	66	119	33
1978	385,945	6,834	261	41	84	29
1977	395,146	7,691	226	50	N.A.	N.A.
1976	433,799	6,310	293	38	N.A.	N.A.
1975	395,528	4,990	N.A.	16	N.A.	N.A.
1974	443,000	5,002	N.A.	N.A.	N.A.	N.A.

Source: Adapted from tables prepared by the WCB

of claims for industrial diseases, to say nothing of all accepted claims. It is important to note that fatalities from industrial diseases, and from cancer as well, represent a very significant share of compensated fatalities in the province. Deaths due to cancer have been over 10 percent of all the compensated fatality claims for workers' compensation in Ontario for each of the past three years.

Table 3 provides a frame of reference for gauging the activity of the WCB. In Table 4 the focus is specifically on successful claims for asbestosis or mesotheliomas from 1969 to 1980. Data in this table reflect the year a claim was accepted. (In some later tables, claims are presented by the year in which the claim was initiated.)

There are several noteworthy elements in this table. First, the experience of a single firm, the Johns-Manville Corporation, dominates the experience of the province. In five of the twelve years shown, one-half or more of the successful claims are from this single firm. The polarity of the distribution is more marked when one considers that the large bulk of the remaining claims come from firms with only one successful claimant in that year.

Table 4

Claims Allowed for Asbestosis or Mesotheliomas

Year	All Claims	Claims From Johns-Manville	Other Firms with more than One Claim	Other Firm One Claim Only
1980	28	5	1	21
1979	26	9	2	8
1978	18	11	0	7
1977	20	9	1	8
1976	26	14	0	12
1975	43	34	0	9
1974	16	7	1	7
1973	24	12	1	10
1972	12	5	1	5
1971	9	4	0	5
1970	12	8	0	4
1969	6	0	0	6
Totals 1969-1980	240	118		

Source: Adapted from tables prepared by the WCB

Indeed, in six of these twelve recent years there were no firms -- other than Johns-Manville -- with more than a single compensated claim.

Table 4 also reflects that the volume of claims jumped substantially in 1975, distorting the movement of the data. Judging solely by the activity of claimants from outside Johns-Manville, 1975 was not an unusual year. Successful claims from other firms have jumped in 1979 and 1980 and have declined sharply at Johns-Manville.

The data in Table 5 are based on the year a claim was initiated and shed light on the industry from which the claim arose. Over 69 percent of all successful claims were from manufacturing, the bulk of these being drawn from several of the province's Johns-Manville establishments. About 20 percent of the claims that were successful during the period 1942-1980 came from the construction industry, many of these persons employed as installers of materials with asbestos content.

The only other sector with any significant number of claims is maintenance. Mining has never been the source of many claims in Ontario for either

Table 5

Claims Allowed for Asbestosis and Mesotheliomas
By Industry of Origin

Year Claim Intiated	Industry				
	Manufacturing	Construction	Warehousing	Maintenance	M
1980	7	4	1	0	
1979	12	3	0	9	
1978	8	1	0	1	
1977	10	6	0	4	
1976	10	1	0	1	
1975	54	5	1	0	
1974	18	4	0	0	
1973	17	6	0	2	
1972	6	6	1	1	
1971	7	4	0	1	
1970	10	4	0	1	
All Years 1942-1980	177	52	3	23	

Source: Adapted from tables prepared by the WCB

asbestosis or the mesotheliomas. This experience sets Ontario apart from Quebec, which has had many of its claims originate in mining.

Table 6 describes the ages of claimants who succeeded in being compensated for asbestosis or mesotheliomas. The age is based on the year in which the original claim was made, though the decision to compensate might have been made at that time or subsequently. Recall that some claimants who were initially denied benefits were later re-assessed and only then found to be compensably impaired.

Asbestosis customarily develops only after some prolonged exposure to asbestos dust. The disease is a progressive one. For both reasons it is a sickness that usually affects older workers. The median age for all successful claimants at the time the claim was begun is over 57 years. Of special note is that about one claimant in six is 65 years or older at the time that the claim was first filed. This suggests that there is a significant number of claimants who would be affected if a strict wage-loss approach to compensation would be developed in Ontario. Under such an approach, persons who lose

Table 6

Claims Allowed for Asbestosis and Mesotheliomas
Ages of Claimants by Year Claim Set-Up

AGES	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	Total
Under 40	1	0	1	0	0	2	0	0	1	1	2	8
40-44	2	0	1	2	5	2	3	2	0	0	0	17
45-49	1	2	1	2	2	2	2	1	0	2	2	17
50-54	2	3	2	4	4	19	0	4	1	4	5	48
55-59	2	2	0	9	3	18	3	2	3	5	6	53
60-64	4	2	6	8	4	13	3	6	2	7	4	59
65-69	3	3	0	1	2	6	1	3	2	3	1	25
70 & above	0	0	2	1	2	0	0	2	1	3	5	16

Source: Based on data made available by the WCB

no earnings would receive no compensation. Since many persons 65 years or older are retired, there would be no compensation for them if industrial disease developed only after retirement.

One of the factors that creates difficulties in summarizing the results of claims for asbestosis (or some of the other pneumoconioses) is that applicants often have their conditions re-assessed periodically. Thus, a claim may be initially denied or treated as a medical assistance only claim, and subsequently, perhaps several years later, be given compensation. The WCB -- and I -- consider such claims to be accepted despite their initial rejection. Some claims that have been denied will eventually result in awards, causing the passage of time to change the numerical findings regarding claims experience. Beyond that, claims that have been accepted but are never re-assessed or are only slightly increased to a higher level of impairment rating may be considered by applicants to be akin to rejections. The measure of acceptance or denial is a shifting one and must be interpreted in the light of the continuing re-assessment process.

Table 7 examines the initial ratings given by the WCB -- and invariably by the ACOCD -- to those persons who were both examined by the Advisory Committee and who received benefits. Some of these individuals were always rated as not impaired but are in the set of accepted claims either because of a medical assistance decision or because there was a subsequent survivors benefit.

Several practices of the WCB emerge from an examination of the data in Table 7. First, a significant number of claims in any given year will be denied initially but re-rated in some subsequent period. About 30 percent of the individuals evaluated by ACOCD who ultimately received compensation were initially rated as not impaired (a zero rating). Secondly, the Board tends to give absolutely low ratings initially. If one excludes the 13 claims that involved total (100 percent) disability and those rated at zero, we are left with 122 cases, 26 percent of which were initially rated at 10 percent disability and 55 percent at from 10 to 20 percent. These initial low ratings, along with those assessed at zero, may reflect either of two possibilities.

Table 7

Claims Allowed for Asbestosis and Mesotheliomas
Initial Rating by WCB by Year Claim Set-Up

%/yr.	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	Total
0%	1	6	2	2	4	26	3	6	1	4	4	59
10%	1	-	-	3	4	5	4	6	-	5	4	32
15%	-	-	-	2	2	10	-	-	-	-	-	14
20%	-	-	-	1	2	4	1	4	-	2	7	21
25%	2	-	1	5	4	4	-	1	-	-	1	18
30%	-	-	1	1	2	3	2	-	1	2	-	12
35%	1	-	1	2	1	-	-	-	-	-	-	5
40%	1	-	-	-	-	-	1	-	-	-	-	2
45%	-	-	-	-	-	-	-	-	-	-	-	0
50%	2	1	2	3	-	3	-	-	-	-	-	11
60%	-	-	3	-	1	-	-	-	-	-	-	4
70%	-	-	-	-	-	-	-	-	-	-	-	0
75%	-	1	-	1	1	-	-	-	-	-	-	3
80%	-	-	-	-	-	-	-	-	-	-	-	0
90%	-	-	-	-	-	-	-	-	-	-	-	0
100%	6	-	2	6	1	1	1	1	-	1	-	13

Source: Based on data made available by the WCB

First, it may be that the ACOCD tends to be strict or even harsh in evaluating claims, particularly initially. Alternatively,it may be that persons with asbestosis are sufficiently well-informed that they seek benefits at an early stage of their impairment. It is not possible to sort out these two effects.

The data in Table 7 also allow us to observe the ACOCD's decisions over the decade. The data suggest that a claim that was ultimately accepted after an ACOCD examination was more likely to be rated as zero in the last six years of the period (1975-1980) than during the first five years (1970-1974). Excluding the claims that were initially rated as 100 percent, about 22 percent were assessed as zero in the first five-year period, compared to 39 percent for the past six years.

Table 7 reveals that only 5 claims have been initially assessed at 25 percent or higher from 1977 through 1980, excluding the two total disability claims from this period. This is below the pattern for the earlier years shown here. Again, this could

reflect a toughening by the ACOCD or it could reflect the changing incidence and source of both the disease and claims in the province over this period.

The data in Table 8 are drawn from claims that were evaluated by the ACOCD and were rated initially as zero impairment. They show that a large proportion of these cases are eventually accepted by the WCB. The reason for the change usually is that subsequent examinations are made, revealing an impaired condition. There are 9 claims in the three most recent years that were rated as zero and none of these have been changed since the initial rating. Based on the past record, however, it is clear that some or indeed a majority of these will eventually become accepted claims.

I have repeatedly referred to the process whereby the ACOCD re-examines claimants to assess whether the worker's condition has deteriorated. The data in Table 9 provide a picture of this. A considerable number of persons, particularly those whose claims were initiated in the early years from which the data are drawn, have been examined (or at least evaluated) by the ACOCD on five or more occasions.

Table 8

Claims - Asbestosis and Mesotheliomas
Does Rating Change Where ACOCD Rates Zero, Initially?

	Year Claim Set-Up										
	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	198
Rating Changed	1	4	2	1	2	23	3	3	0	0	0
No Rating Change	0	2	0	1	2	3	0	3	1	5	3

Source: Based on data made available by the WCB

Table 9

Claims Allowed for Asbestosis and Mesotheliomas
Frequency Evaluated by ACOCD

Number of Evaluations	Year Claim Set-Up											
Frequency/yr.	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	Total
0-4	11	6	6	16	13	43	10	20	10	25	25	175
5 & more	3	6	7	11	9	19	2	0	0	0	0	57
												232

Source: Based on data made available by the WCB

Two persons whose claims were initiated in 1976 were seen four or more times by the end of 1980. As a rule, the more serious the person's condition, the more likely it is that he will be re-assessed within a year. The least likely to be re-assessed are those claimants who are given zero ratings initially and are judged to be in good health at that time.

Table 9 examined the frequency with which claimants are re-assessed. In Table 10, I focus on those claims applicants who were evaluated by the ACOCD on more than one occasion to determine whether their ratings should be changed. Note that a few claimants had ratings changed four or five times since their initial assessment. For those rated either initially at 100 percent or in one of the later years in this period, obviously ratings were least likely to change. It is interesting that there are so many claimants with initial ratings that were never modified by the Board even on re-examination. Several of these no doubt were persons who died during the period under review. But others must have had conditions that were stabilized at the initial examination. Excluding the totally disabled and the

Claims Allowed for Asbestosis and Mesotheliomas

Where Rated by ACOCD - Frequency of Rating Change - Year Claim Set-Up

Initial Rating	Rate Change Frequency 1970						Rate Change Frequency 1971						Rate Change Frequency 1972					
	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
0%	-	1	-	-	-	-	2	1	1	1	1	-	-	-	1	1	-	-
10%	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
15%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
20%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
25%	1	-	-	-	1	-	-	-	-	-	-	-	-	-	-	1	-	-
30%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-
35%	1	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-
40%	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
45%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
50%	1	-	1	-	-	-	-	1	-	-	-	-	1	-	1	-	-	-
60%	-	-	-	-	-	-	-	-	-	-	-	-	-	2	1	-	-	-
70%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
75%	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-
80%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
90%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
100%	6	-	-	-	-	-	-	-	-	-	-	-	2	-	-	-	-	-

(continued)

Table 10 (continued)

Claims Allowed for Asbestosis and Mesotheliomas

Where Rated by ACOCD - Frequency of Rating Change - Year Claim Set-Up

Initial Rating	Rate Change Frequency 1973						Rate Change Frequency 1974						Rate Change Frequency 1975					
	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
0%	1	-	-	1	-	-	2	1	1	-	-	-	3	17	4	2	-	-
10%	-	-	-	2	1	-	2	-	2	-	-	-	1	3	1	-	-	-
15%	-	2	-	-	-	-	-	2	-	-	-	-	2	5	3	-	-	-
20%	-	-	-	-	-	1	-	1	1	-	-	-	2	-	1	1	-	-
25%	2	2	1	-	-	-	-	1	3	-	-	-	2	1	1	-	-	-
30%	1	-	-	-	-	-	1	-	1	-	-	-	2	-	1	-	-	-
35%	-	1	1	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-
40%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
45%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
50%	2	1	-	-	-	-	-	-	-	-	-	-	2	-	1	-	-	-
60%	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-
70%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
75%	-	1	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-
80%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
90%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
100%	6	-	-	-	-	-	1	-	-	-	-	-	1	-	-	-	-	-

Table 10 (continued)

Claims Allowed for Asbestosis and Mesotheliomas

Where Rated by ACOCD - Frequency of Rating Change - Year Claim Set-Up

Initial Rating	Rate Change Frequency 1976						Rate Change Frequency 1977						Rate Change Frequency 1978					
	0	1	2	3	4	5	0	1	2	3	4	5	0	1	2	3	4	5
0%	-	3	-	1	-	-	3	3	-	-	-	-	1	-	-	-	-	-
10%	1	3	-	-	-	-	3	3	-	-	-	-	-	-	-	-	-	-
15%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
20%	1	-	-	-	-	-	-	3	-	-	-	-	1	-	-	-	-	-
25%	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-
30%	1	1	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-
35%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
40%	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
45%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
50%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
70%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
75%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
80%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
90%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
100%	1	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-

(continued)

Table 10 (continued)

Claims Allowed for Asbestosis and Mesotheliomas

Where Rated by ACOCD - Frequency of Rating Change - Year Claim Set-Up

Initial Rating	Rate Change Frequency 1979						Rate Change Frequency 1980					
	0	1	2	3	4	5	0	1	2	3	4	5
0%	4	-	-	-	-	-	4	-	-	-	-	-
10%	5	-	-	-	-	-	4	-	-	-	-	-
15%	-	-	-	-	-	-	-	-	-	-	-	-
20%	2	-	-	-	-	-	7	-	-	-	-	-
25%	-	-	-	-	-	-	1	-	-	-	-	-
30%	1	1	-	-	-	-	-	-	-	-	-	-
35%	-	-	-	-	-	-	-	-	-	-	-	-
40%	-	-	-	-	-	-	-	-	-	-	-	-
45%	-	-	-	-	-	-	-	-	-	-	-	-
50%	-	-	-	-	-	-	-	-	-	-	-	-
60%	-	-	-	-	-	-	-	-	-	-	-	-
70%	-	-	-	-	-	-	-	-	-	-	-	-
75%	-	-	-	-	-	-	-	-	-	-	-	-
80%	-	-	-	-	-	-	-	-	-	-	-	-
90%	-	-	-	-	-	-	-	-	-	-	-	-
100%	1	-	-	-	-	-	1	-	-	-	-	-

claims evaluated in the past two or three years, the modal applicant had one rating change over the period.

Thus far the analysis has focused primarily on accepted claims. Below I turn to those claims that have not been accepted. In Table 11, I describe claims for asbestosis or mesotheliomas that have never been accepted by the WCB. Again, because the experience of a single firm so dominates the data, rejected applicants from there are shown in separate columns. From 1970 through 1980, our data show that there were 205 claims for mesotheliomas or asbestosis that were rejected: that is, they were not entitled to compensation benefits based on one or even several evaluations of the claimant. This was about 46 percent of all claims initiated over this period for asbestosis or pleural or peritoneal mesothelioma. About 8 percent of these were claims for survivors benefits; the balance involved claims for disability benefits. (These death claims do not include cases where disability benefits have been granted but survivors benefits are denied.) Excluding the death claims, 54 percent of the rejected claims came from

Table 11

Denied Claims for Asbestosis or Mesotheliomas
By Year, Fatal and Non-Fatal

Year Claim Set-Up	Fatal		Non-Fatal		Total Rejected	Total Accepted
	JM	Non-JM	JM	Non-JM		
1980	1	2	10	23	36	25
1979	1	2	4	21	28	25
1978	0	1	8	14	23	10
1977	1	2	16	8	27	20
1976	1	1	25	7	34	12
1975	2	0	33	7	42	62
1974	0	0	2	2	4	22
1973	0	1	1	0	2	27
1972	0	1	0	1	2	13
1971	0	0	2	2	4	12
1970	1	0	0	2	3	15

Source: Based on data made available by the WCB

applicants who were or had been employees of the Johns-Manville Corporation in Ontario. (This compares closely to the compensated claims where, from 1970 to 1980, about 50 percent of those claims were from this firm. See Table 4.)

Comparing the last two columns suggests that far more claims have been denied in recent years, relative to accepted claims, than in earlier years. While other data show that this is apparently true, a strict comparison based on this table is flawed. Recall that some of the cases denied will eventually be accepted and the greatest changes are yet to come for claims initiated in more recent years.

The persons with claims denied tend to be younger than those whose claims were accepted. The data in Table 12 (as in Table 6) are based on ages as of the date of the initial claim for persons with asbestosis or mesothelioma claims. The data are limited to the years 1975 to 1980 because of the rather small number of rejected claims prior to 1975. Persons whose claims emanated from Johns- Manville were about the same age as those workers from other

Table 12

Denied Claims for Asbestosis or Mesotheliomas
Median Age of Claimant

Year Claim Set-Up	Johns-Manville Age	(Number of Claims)	Non Johns-Manville Age	(Number of Claims)
1980	53.0 yrs.	(11)	52.5 yrs.	(22)
1979	47.0	(5)	60.0	(18)
1978	54.0	(7)	51.0	(13)
1977	51.5	(14)	60.0	(9)
1976	53.5	(26)	45.0	(7)
1975	51.5	(34)	50.5	(6)

Source: Based on data made available by the WCB

employers. For both groups the median age is in the early fifties. As this cohort ages, it seems certain that some of these claimants will be accepted for compensation.

The frequency with which the ACOCD examines rejected claimants is shown in Table 13. The data are only for persons with asbestosis claims. A significant number of rejected claimants (109 persons) were never seen by the ACOCD for cases that were initiated from 1975 to 1980. It should be noted that 17 of these were rejected as "Code 33's": persons whose claims were dropped because they provided inadequate or no information on which the WCB could act. For 7 persons initiating claims between 1975 and 1980 the ACOCD made an evaluation four or more times and in every instance found the impairment not compensable. Yet this is clearly the extreme. The typical asbestosis claim that is rejected is either seen by the ACOCD only once or not at all.

The data in Table 14 summarize information in Tables 13 and 7. Table 14 lists the number of persons evaluated by the ACOCD whose claims were

Table 13

Denied Claims for Asbestosis
Frequency of Evaluation by ACOCD

Year Claim Set-Up	Number of Times Seen by ACOCD 0	1	2	3	4 or more
1980	26	7	0	0	0
1979	14	7	2	0	0
1978	16	4	1	1	0
1977	18	4	3	0	1
1976	20	6	4	3	0
1975	14	9	4	7	6
1974	1	2	0	0	1
1973	0	1	0	0	1
1972	0	1	0	0	0
1971	0	2	1	0	1
1970	0	1	1	0	1

Source: Based on data made available by the WCB

Table 14

Asbestosis Claims - Evaluated by ACOCD
Year Claim Initiated

Year Claim Initiated	Evaluated by ACOCD		Not Evaluated by ACOCD
	Accepted	Denied	Denied
1980	16	7	26
1979	14	9	14
1978	2	6	16
1977	18	8	18
1976	12	13	20
1975	56	26	14
1974	22	3	1
1973	26	2	0
1972	12	1	0
1971	8	4	0
1970	14	3	0

Source: Based on data made available by the WCB

either accepted or denied and those whose claims were denied without such an evaluation. Only asbestosis claims are considered. While the data give another perspective on the use of the ACOCD in administering claims, the reader must remember that some claimants are not evaluated by the ACOCD initially, but the Committee may be asked to assess them at a later date as their condition changes. Table 14 shows only whether the applicant has ever been seen by the Advisory Committee. The majority of persons actually evaluated do eventually have their claims accepted. The table provides some perspective on the number of denials that do not result from an ACOCD decision, relative to successful and unsuccessful claims which have been evaluated.

Table 15 examines the costs of accepted claims for mesotheliomas or asbestosis. It provides some idea of the expenses incurred by the WCB in such cases. (The figures in the table are calculated as arithmetic means.) The table was constructed in the following way: Only claims involving permanent disability awards or fatality/survivors awards are considered. Accepted claims involving only temporary

Table 15

Mean Costs of Accepted Claims for Asbestosis and Mesotheliomas

Year	Permanent Disability Only		Fatality Only		Permanent Disability and Fatality	
1980	$24,000	(13)*	$58,000	(3)	$ -	(0)
1979	26,000	(11)	64,000	(8)	-	(0)
1978	40,000	(1)	52,000	(7)	-	(0)
1977	23,000	(12)	66,000	(5)	125,000	(2)
1976	28,000	(11)	57,000	(1)	-	(0)
1975	25,000	(46)	45,000	(6)	108,000	(8)
1974	32,000	(15)	43,000	(2)	90,000	(4)
1973	44,000	(11)	45,000	(5)	77,000	(9)
1972	37,000	(6)	37,000	(2)	70,000	(5)
1971	27,000	(2)	27,000	(5)	83,000	(3)
1970	22,000	(3)	37,000	(2)	63,000	(9)

* number of observations

Source: Based on data made available by the WCB

partial or temporary total disability or medical assistance only are excluded from consideration. Where a temporary disability award preceded a fatality award with no permanent disability rating or benefit, the cost of the claim was the sum of all WCB payments (for example, temporary total plus survivors benefits plus the burial allowance) and it was included with the fatalities. Several death claims were not considered because there were no survivors and, hence, little or no costs for the WCB. Where there were temporary benefits awarded prior to a permanent pension being granted, these were added to the costs of the pension. Administrative expenses incurred by the WCB are not considered here.

The figures in Table 15 are based on the year the claim was initiated. In each year the separate columns refer to permanent disability claims, fatality claims or costs where a claim involved both a permanent disability followed by a survivors award. The temporary benefits costs are based on the actual outlays by the WCB. They depend in each case on the worker's earnings prior to disability, the maximum in effect at the time, and very heavily on the length of time for which benefits

were paid. The permanent disability and death benefits do not represent actual expenditures from case to case. Instead, they are based on the reserves set aside by the WCB at the time the award is made for the purpose of providing future benefits to the compensation recipients. In both cases a major factor determining the cost of the claim is the age of the beneficiary, since the younger the person is, the more years of benefits will likely have to be paid. In permanent disability cases the size of the reserves is also a function of the extent of impairment and the worker's previous earnings level, since the pension is based on both variables.

The data in Table 15 cover the eleven-year period 1970-1980. There were fewer observations in 1980 than there were accepted claims since the WCB had not calculated the costs of several of these claims or at least did not have the figures available. Finally, it should be noted that a few claims involve costs based on awards for periods prior to the time the claim was started. For example, a claim may have been initiated in 1975 but the ACOCD, the Board doctors, or the claims adjudicator decided that benefits should be made retroactive to 1973. A more

common occurrence, however, would involve a 1975 claim that does not involve an award until 1978.

The data reveal that the most expensive claims are those that involve disability and subsequent survivors awards. Since most of those persons with disability only benefits are still living, the WCB should expect to find an increasing number of survivors awards as these persons age and die.

Until now, our attention has been on claims for asbestosis or for mesotheliomas and asbestosis. I turn now to the experience of the WCB in claims involving cancer, including the mesotheliomas. Table 16 is based on claims decisions (acceptances or denials) involving cancers for each year from 1976 through 1980 and the cumulative experience from 1942 to 1980.

Since 1942 the WCB has decided 502 claims involving cancer. Of these 144 (29%) were based on an alleged asbestos exposure. It appears that the WCB is more likely to accept these asbestos-linked claims than the cancer cases involving other hazards. About 31 percent of all accepted cancer claims involved asbestos while only 19 percent of the denied

Table 16

Accepted and Rejected Claims for Cancer, by Cause

Selected Years

Site	Cause	Year of Decision 1942-80	1980	1979	1978	1977	1976
Lung	Asbestos	*53-11	6-5	4-2	6-2	2-1	10-0
Sinus	Asbestos	0-0	0-0	0-0	0-0	0-0	0-0
Mesotheliomas	Asbestos	48-5	13-2	12-3	2-0	4-1	5-0
Gastro-intestinal	Asbestos	7-7	0-3	0-0	3-1	3-2	1-2
Larynx	Asbestos	4-9	1-2	1-3	2-4	0-0	0-0
All Asbestos		112-32	20-12	17-8	13-7	9-4	16-2
All Sites	All, except Asbestos	367-135	43-13	48-17	27-31	41-34	20-2

* First number in each column is accepted claims in that year. The second number represents claims denied.

Source: Adapted from tables prepared by the WCB

cases involved asbestos. Viewed somewhat differently, 22 percent of the cancer claims for asbestos have been denied compared to 27 percent of all non-asbestos cancer claims. If the asbestos-related cancer claims are considered excluding the mesotheliomas, about 30 percent of these have been rejected.

About 90 percent of the accepted cases for asbesto-related cancers involved lung cancer or one of the mesotheliomas. The few claims for other cancers involved either gastro-intestinal cancer or laryngeal cancer and claims decisions for either have occurred only in the past few years. Aside from the mesotheliomas, there is no apparent upward trend in the incidence of these claims since the WCB began accepting them.

Table 16 may shed light on a very important issue raised earlier, namely: Are many asbestos-related diseases going uncompensated because no claims are being made for them? Some idea on this, at least as it pertains to cancer, can be gained with the use of some fairly heroic assumptions. All persons belonging to the International Association of Heat and Frost Insulators and Asbestos Workers, AFL-CIO,

CLC, in the U.S.A. and Canada on January 1, 1967, have been monitored by the Mt. Sinai School of Medicine, N.Y., under the direction of Dr. I. Selikoff. In particular, any deaths from this cohort of asbestos workers occurring during the ten years 1967-1976 have been investigated with a view to determining causality. By comparing the number of fatalities from each cause of death to the expected number of deaths for white male, age-specific U.S. death rates for the same period, Selikoff was able to calculate excess mortality rates for various forms of cancer, non-infectious pulmonary diseases and all other causes.*

Selikoff reported 175 fatalities due to mesotheliomas, diseases rarely found in the general population. (There are two forms of this cancer: pleural and peritoneal.) Using this as a benchmark by setting it equal to an index of 100, I can index the number of fatalities that Selikoff found due to lung

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* The table showing these data can be found in Peter S. Barth, "Compensation for Asbestos-Associated Disease: A Survey of Asbestos Insulation Workers in the U.S. and Canada," Report to the U.S. Department of Labor, Draft (New York: Mount Sinai School of Medicine of the City University of New York, Environmental Sciences Laboratory, January 1981), p.5.

cancer as 278, the number of laryngeal cancers as 6, and the index number of cases involving cancers of the esophagus, stomach and colon-rectum, cumulatively, as 57. (We have excluded in the foregoing the related cancer of the pharynx.) A similar index is created based on all decisions of the WCB (accepted and rejected) involving asbestos-cancer claims by setting the 53 claims for mesotheliomas equal to an index of 100. The results are seen in Table 17. The data show a small excess number of claims for laryngeal cancers and a substantial shortfall of claims for the other two groups, especially lung cancer. Since it can be argued that a better comparison would be based on claims accepted by the WCB, as compared to claims for which a decision was rendered, column 3 of Table 17 was constructed. It relates the three groups of cancers, not to all claims for mesotheliomas, but only to the 48 claims which have been accepted. The disparity with the Selikoff data are even greater in each category, suggesting a substantial number of potential cancer cases are not being brought as claims to the WCB. Clearly the extent of this missing group depends heavily on the size of the

Table 17

Types of Cancer in Asbestos-Related Claims, Indexed

Site	Observed Causes of Death, Cancer in Asbestos Workers (Selikoff)*	All Claims to the WCB, Cancer, Asbestos Involvement	Accepted Claims by the WCB, Cancer, Asbestos Involvement
Mesotheliomas	100	100	100
Lung	278	121	110
Larynx	6	25	8
Stomach, Colon-rectum, Esophagus	57	26	15

* Indexed so that mesotheliomas = 100

reference group; that is, how many mesothelioma cases are actually coming to the Board's attention.

Earlier I suggested that some heroic assumptions are made in this type of analysis. The findings from Table 17 are therefore only suggestive and should be judged with caution. There are several reasons for this caution. First, Selikoff's population is very different from those seen by the WCB. While his group is asbestos workers only, the claimants to the WCB come from a broader spectrum of occupations. The implication of this difference is that the exposures involved for the two populations are likely to have been quite different in duration and intensity. A second significant difference is that some of the claims to the WCB involve living persons while Selikoff's data are taken only from fatalities. A worker who has been successfully treated for cancer could receive compensation but would not have been included in Selikoff's cancer count. Since these four groups of cancers are known to involve different probabilities of recovery, this disparity in the data sets is of some importance.

A third source of difference is also significant. The purpose of Selikoff's work compelled him to make a very substantial effort to determine precisely the cause of death. By contrast, this precision is not needed where the WCB finds that any of the two or three possible causes is compensable. For example, where a long-term asbestos insulation worker is found to have either lung cancer or a pleural mesothelioma, the precise identification of the primary tumour site is academic as compensation will be paid in either case. Again, the findings in Table 17 are only suggestive that the WCB is not receiving claims for asbestos-related cancers that would be compensable, particularly lung cancers. The matter would benefit from further inquiry, and possibly lead to additional outreach activity.

From 1970 to 1980 there were 39 successful claims for fatality due to mesotheliomas. Of these, 29 involved only the claim for death benefits while 9 cases involved both survivors benefits and temporary total or permanent disability awards. In the remaining case, the worker's earlier claim for disability benefits for asbestosis had been denied but death benefits were awarded.

Since mesotheliomas rarely develop except as a result of an exposure to asbestos, one might wonder why any such claim is denied. In fact, there is a dispute in the medical literature about exactly how rare such instances are. A mesothelioma can result from an exposure to asbestos that is not related to one's work. Indeed it is now well-established that family members of asbestos workers are subjected to the risk of mesotheliomas from the dust carried home on a worker's clothing or body. These persons are ineligible for workers' compensation. For such reasons the WCB cannot be expected to automatically compensate every case of mesothelioma that develops in the province.

A reading of virtually all the claims files involving mesotheliomas does indicate that the WCB has required very little proof of workplace exposure for compensation where a person has a mesothelioma. These claims typically do not involve the ACOCD unless the person has earlier had a claim for asbestosis. The Board medical staff usually make the decision themselves regarding compensability.

There appear to be two sorts of claims involving the mesotheliomas that are not readily accepted. First, there may be a question regarding the diagnosis of the disease. Aside from whether or not such a tumour exists, the more difficult question is whether or not it is a primary tumour. Even a pathologist may have difficulty determining whether a cancerous condition metastasized and spread to the pleura or peritoneal cavity, or if it originated in either location. The more likely reason that a claim for a mesothelioma has been rejected is that the worker's job history reveals no occupational exposure to asbestos. Many of the claims for mesotheliomas seem to have originated because physicians either contacted the WCB or urged the worker to begin a claim as soon as the disease was diagnosed. These doctors have been made aware of the workplace-asbestos link in mesotheliomas. Yet, if the WCB can find no record of previous exposure at work, the claim will be denied. In one rejection, the WCB seemed to suspect that the exposure had occurred while the man had previously lived in Europe. The Board believed that he could have been exposed there to asbestos either through work or his residential proximity to a facility using the substance. Several white collar

workers with detailed backgrounds done on their work experience were not compensated where no exposure to asbestos was uncovered.

With one exception that I came across the Medical Services Division has treated claims for mesotheliomas as compensable where there was virtually any workplace exposure to asbestos. The one exception, a 1979 claim, was one of the exceptionally few cases where the appeals adjudicator allowed a claim that had been recommended for rejection by the Board doctors.

From 1970 to 1980 there were approximately 250 successful fatality claims involving cancer for various sites and hazards. Over 99 percent of all the deceased workers were males, and over 93 percent were married at the time the claim was initiated. The median age for this cohort of persons whose death was compensated was about 58 years. Two-thirds of all these successful cancer claims were for fatality only. About one claim in six involved some temporary total or permanent disability benefits being awarded in addition to death benefits. The balance, or about

15 percent of this group, were denied disability benefits, only later to have death benefits awarded.

A. British Columbia and Quebec

It is instructive to examine the quantitative experience of other provinces with asbestos disease and workers' compensation. Some information from Quebec and British Columbia is available -- the experience of the other, less populous provinces appears to be that asbestos cases are extremely rare. Indeed, the number of cases is not very large in the case of British Columbia. From 1970 through 1980 the WCB there accepted 40 claims for all the asbestos-related diseases, and for all years until July 16, 1981 the number accepted was 49. This latter figure represented 47 percent of the 104 claims made by the July 1981 date. Of the 55 asbestos-related claims that were not accepted, 30 had been suspended, 19 were rejected, and 6 were under adjudication. Of these 104 claims, 22 originated in the insulation industry, 8 were from pipefitters, steamfitters, laggers, 9 were in mining, milling and 10 were shipbuilders, joiners, dockworkers. The median age of successful claimants was about 58 years.

Workers' compensation for lung cancer is compensable only in the presence of asbestosis in British Columbia. This is identified in "Schedule B" of the statute. Cancer of the pharynx or larynx also would be compensable only in the presence of asbestosis though this does not appear on the Schedule. From 1970 till February 17, 1981, the British Columbia WCB had only 28 claims for cancer in asbestos workers. Twelve of these were for lung cancer (7 have been accepted) and 14 were for mesotheliomas (14 were accepted). (It should be noted that the one denied claim here was judged to be pharyngeal cancer that had metastasized.) The remaining claim involved cancer of the pharynx and its outcome is not clear.

In Quebec in calendar year 1979 about 2.7 percent of all newly compensated claims (195,000) involved industrial illnesses. Of the 223 fatalities attributed by the Commission to the workplace in 1978, 19 (8.5 percent) were industrial disease cases. Several significant differences distinguish conditions in Quebec from Ontario. First, Quebec has a considerable asbestos mining sector. Claims from

there continue to be submitted based on working conditions in earlier years. Secondly, Quebec is much closer to British Columbia than to Ontario in the assessment of malignancy claims. Lung cancer is only compensable in the presence of asbestosis and gastro-intestinal, laryngeal and pharyngeal cancer have not been compensated. From 1965 to mid-1981 approximately 122 claims for lung cancer and 30 for mesotheliomas have been compensated. Since 1965 there have been about 500 compensated claims for asbestosis arising out of the primary industrial sector (essentially mining) in Quebec. Data are not available on claims for asbestosis that developed in the secondary sector (primarily manufacturing) and the tertiary sector (services such as maintenance and repair).

Chapter VII Outreach Programmes

One of the critical questions regarding any workers' compensation board and asbestos diseases is the extent to which claims are being brought to the agency. Potentially worthy claims may not be coming to the agency's attention. One of the most common reasons for this is that the worker, his doctor, survivors, the employer, the union and others involved are unaware that the illness is due to asbestos. Such ignorance could stem from several sources. First, the worker's asbestosis could be diagnosed improperly and might not appear to be caused by a hazard found at work. Another factor could be that the primary site of a cancerous tumour is wrongly identified. Thirdly, perhaps no one involved is aware that the worker was once exposed to asbestos on the job. These and other reasons have led some to suspect that cases are being missed.

Has the Ontario WCB done anything to assure that potentially worthy claims are brought forward?

How adequate is coverage currently? One simply cannot answer this question, given the present state of scientific knowledge. The findings in Chapter VI (see Tables 16 and 17) are very tentative, but certain generalities can be offered. There has been considerable publicity in Ontario about the hazardous nature of asbestos. The persons I have interviewed seemed to believe that the matter was of considerable concern to workers, employers and physicians, particularly in the province's larger cities. One can speculate that the high level of consciousness is bringing appropriate workers into the compensation process.

A piece of evidence that demonstrates this increasing awareness derives from a claim that the WCB denied. The worker acknowledged that he had no symptoms of illness nor had he been advised by his doctor of any health problems. His claim, he indicated, was simply to put his name on the record, since he had formerly worked around asbestos and anticipated developing one form of compensable disease or other in the years ahead.

A more activist programme was begun by the WCB in late 1976 to identify potential claimants. The event that precipitated the programme was the announcement that the WCB had recognized, for policy purposes, gastro-intestinal cancer as an industrial disease in workers exposed to asbestos. Subsequently the Occupational Health Branch (then in the Ministry of Health) provided a list of 99 companies considered as the most likely sources of claims. A team of persons from the WCB visited some of these companies (about one-third) and the balance were contacted by mail. Each company was informed or reminded that the WCB would accept claims for specific forms of cancer in workers with asbestos exposure; lung cancer, mesotheliomas and gastro-intestinal cancers were specifically identified in the letters to these firms. In October 1976, the Ontario Federation of Labour was notified of the programme and its help was solicited in contacting important local unions.

The programme was not successful initially. In a memorandum in February 1979, a staff person reported that at that point there were 22 claims resulting from the outreach effort. Of these 20 had

been denied, 1 had been withdrawn and 1 claim was still in pending status.

In March 1979, the programme was extended to the shipbuilding industry. Seven major shipbuilders were visited and an equal number were contacted by mail. An estimate was made by one staff person that about 25,000 had been employed in shipbuilding in Ontario during World War II and that many had been exposed to high levels of asbestos dust. The key labour union was visited in mid-1980 (it had been visited by team personnel in April 1977 also) and the effort explained. By December 1979, the programme was essentially ended subject to the acquisition of new leads. By July 1980, a new score card indicated that the effort had resulted still in 22 claims being established of which 19 were denied, 2 were allowed and 1 was withdrawn.

The number of claims established and the number allowed that resulted from the programme was unimpressive. Yet how is one to judge the effectiveness on that basis when no underlying population estimates exist? Employers were encouraged to locate

possible claimants, being told that they would not bear the costs of these claims. The pertinent unions were notified and the medical community was drawn in at least to some extent. It is possible that the programme resulted in new claims that were not credited to the effort. Conceivably, in some indirect manner, it alerted subsequently successful claimants to their rights.

The identification programme's goals became blurred in mid-course. At first the effort was directed at publicizing the WCB's new policy of compensating for gastro-intestinal cancers. Later it appears to have been directed at bringing in cases for any asbestos-related cancers. Strikingly, there was no comparable publicity given to the policy change in 1978 to accept laryngeal cancers, nor was there any special effort to identify "hidden" cases of asbestosis. If the goal was primarily information dissemination rather than identifying new claims, the "score card" above is a less than adequate criterion by which to evaluate the programme.

It may be helpful to divide workers into categories based upon their contact with asbestos as a way to clarify the scope of the WCB's programme:

Table 18

Sources of Exposure to Asbestos -- Examples

	Process-Exposure	Industry	Occupation
1.	Primary	Mining	Miner
2.	Manufacturing Products	Asbestos pipe	Production line operative
3.	Installation	Shipbuilding, construction	Lagger
4.	User of manufactured products	Brake shoe repair	Auto mechanic
5.	Incidental	Education, building demolition	School janitor, labourer

The table above classifies workers by the process which brings them into contact with asbestos. The industry and occupational categories are used as examples. The difference between row 3 and 4 is largely one of degree. Row 1 workers received no attention under the special identification programme since the industry no longer exists in Ontario. (Note: This suggests of course that those extractive processes that encounter asbestos as a by-product were also neglected.) The special identification

programme aimed initially at workers drawn from group 2 and then expanded into group 3 processes. Groups 2 and 3 may well be where past exposures to asbestos have been the heaviest in the province but they are also likely to involve those employees most aware of the nature of the hazard. Groups 4 and 5 were not involved in the WCB's programme. The past exposures to asbestos in these processes may or may not have been slight. It is likely, however, that many of these workers were (and are) unaware of the nature of the hazard to which they have been exposed. They are also likely to be employed in many small, decentralized establishments rendering any outreach programme costly and slow. With hindsight it is easy to see that the WCB's approach -- aiming at group 2 and 3 processes -- did not yield many new claims, especially accepted ones. Perhaps in any future efforts of this type the WCB should consider trying to reach persons from group 4 or 5. It might aim specifically at those workers and employers whose knowledge about their past or present exposures to asbestos is most limited.

Two other comments about the WCB's outreach efforts are necessary. First, outreach programmes

are still very uncommon among workers' compensation agencies. In some jurisdictions, such projects are thought to be outside the scope of the compensation agency and are left to other agencies, public or private, or not undertaken by anyone. Moreover, a very major publicity effort in the latter part of the 1970's by the U.S. government to identify asbestos-injured workers in federally operated shipyards is acknowledged to have met with failure or at least very little response.

Secondly, the staff of the WCB did undertake a detective-like effort to identify persons who contracted asbestos diseases from exposures in a gas mask assembling facility in Ontario during World War II. The process began by first establishing that a claimant's illness stemmed from an occupational exposure in this facility and then tracing other persons with the same source of exposure. The initial claim from this source was brought only in June 1978. That asbestos was involved was irrefutable since the person died from a mesothelioma and the lungs were heavily laden with asbestos fibres. The claim was brought by the man's doctor because of

the known relationship between asbestos and this form of cancer. Working backwards, and with confidence that asbestos had to have been involved in the person's past, the industrial source was isolated and several other claims identified. This effort was a genuine success story for the Board.

Chapter VIII

Special Rehabilitation Assistance Programme

Rarely if ever has the WCB been involved with a less successful effort than with the Special Rehabilitation Assistance Programme (SRAP). The programme could serve as the source for a lesson in public administration courses on how not to formulate and operate government programmes.

Since 1926 the WCB has been involved in efforts to relocate workers in order to reduce or eliminate their exposure to hazards that have already begun to harm them. The WCB operated a major effort of this sort for uranium miners employed at Elliot Lake in 1975. That programme sought to provide financial assistance, counselling and other aid as needed to relocate miners who appeared to be at risk from diseases associated with this type of mining. This project, and others like it that have been operated in other jurisdictions, frequently involve moving an underground miner to an above-ground site.

Such forms of relocation allow the person to be removed from risk without causing him to sever ties with his employer, his union and his community. Such programmes can flounder, however, on matters of pay differentials, seniority status, the availability of adequate numbers of positions above-ground and criteria for identifying eligible persons. The general reaction that I encountered to the Elliot Lake project is one of satisfaction with the WCB's work.

A programme of the type in effect at Elliot Lake was announced by Ontario's Minister of Labour in the spring of 1976 to apply to workers at risk from asbestos. The background of this announcement is not entirely clear. Some WCB staff believe that it was made without any consultation with Board personnel. Even if that is correct, there is evidence to suggest that some such project for asbestos workers was being contemplated by the WCB.

Regardless of whether or not this announcement was pre-emptive, many of the staff at the WCB believe it to have been the product of political

expediency rather than sound medical considerations. The environment at that time was volatile, with the WCB and the government under considerable and well-publicized attack. In the view of many Board staff, the announcement of the programme for asbestos workers was little more than a reaction to the attacks, as a way to demonstrate that "something" was being done.

A primary source of objection to the SRAP came from the Medical Services Division of the WCB. The roots of these criticisms were and continue to be certain basic medical issues. First, how does one identify or define the Asbestos Fibre Dust Effect (AFDE) condition? This circumstance exists where the worker does not have a compensable asbestotic condition but is approaching it. Such a worker would have, presumably, some radiological symptoms or other indicator of low level impairment or near impairment. Secondly, certain staff in the Medical Services Division believe that no evidence exists demonstrating that removing persons who have AFDE from very low levels of exposure to asbestos will be medically beneficial. In one internal memorandum, the core of

the argument is presented, "...it is by no means agreed that withdrawal from exposure will stop or slow progression of asbestosis." In the same memorandum, another study is cited that: "...indicates that there is no way to pinpoint those with minimal asbestosis in life in order to remove them from further exposures early."

The result of all this was that a programme of political origin was thrust on the WCB, with the burden for much of the implementation in the hands of staff who had serious reservations on professional grounds that appropriate programme beneficiaries would be identified or their health conditions stabilized. The objection was not to the application of such rehabilitative efforts in general, but to the application of such efforts to workers exposed to asbestos.

The problems noted above were serious enough in terms of carrying out the scheme but other developments severely compounded them. Much of the effort was aimed at a single facility in the Metropolitan Toronto area. A plant of the Johns- Manville Corporation was the continuing source of a highly disproportionate share of claims for compensation

for asbestos-related disease. The programme therefore was directed almost entirely at this establishment. Relations between the existing union leadership and the WCB staff who sought to implement the programme rapidly became poisoned, and this gravely undermined the administration of the effort. There is no point in reciting the various charges made by one side or another that focused on the personalities of the participants. These undoubtedly made everything more difficult. But a key issue that transcended personalities was the environment of the Johns-Manville facility. When the union did encourage its members to avail themselves of the SRAP, the WCB was willing to accept applicants only from those sections of the plant where there was some continuing exposure to asbestos dust. The WCB argued that only persons employed in and around the transite pipe production department might benefit from relocation as this was the only site where dust counts reached or exceeded the exposure limit of 0.5 fibres/cc set by the programme. Once the union accepted the value of the SRAP, it urged that employees from anywhere in the plant be allowed to participate, not simply those from transite pipe, on the grounds that hazardous levels of asbestos existed throughout the plant.

In the midst of the conflict between WCB staff and the union leadership were the employees. Their circumstances were extremely difficult for a variety of reasons. First, there was an understandably high level of anxiety for many of them because of fear regarding their own health. By 1977 and 1978 many of their friends and fellow-workers had died or become disabled from asbestos-related disease. Any indication of incipient disease in themselves was grounds for grave concern. Secondly, many of the employees involved were relatively unskilled, particularly in relation to job opportunities outside the Manville plant. Recall also that workers with pre-asbestotic conditions or with asbestosis were necessarily middle-aged or older workers, making alternatives rather limited for them in the labour market. Finally, it must be noted that these concerns were heightened by fears that the plant's difficulties would lead to its partial or full closure. All this suggests a state of mind that few persons can fully appreciate and that made for extreme difficulty in implementing what was an already flawed policy.

The programme was met at first with little approval by workers and their union. Over time, several factors changed that. The programme was designed initially to provide rehabilitation benefits for up to one year in cases where a job transfer resulted in some earnings loss. (Other benefits were provided, including moving allowances, travel expenses, and the like.) Late in 1976 this one-year limit was removed, considerably enhancing the programme's attractiveness. Secondly, Johns-Manville agreed to provide a continuation of many of its fringe benefits to those employees who entered the programme. For many long-term employees, the prospect of losing such benefits had discouraged them from entering the SRAP. Thirdly, early in 1977 a decision was made that a worker's pension for permanent disability was not to be deducted from any benefits provided for wage loss. Thus, if a relocated employee was not yet re-employed his benefits from the WCB were 75 percent of his previous (gross) wages at Johns-Manville, plus any pension for permanent disability, with some workers maintaining their insurance fringe benefits from the company. On top of this, the worker was being persuaded that he was to be removed from the hazards posed by continuing asbestos exposure.

Table 19 was prepared by the WCB in 1981 and summarizes the process of screening and selection for the SRAP with results through 1980. The table summarizes the reasons given for the small-scale nature of the programme. Yet it hardly provides an evaluation of the experience for either the WCB or the employee participants. Perhaps the most striking outcome, as evident from Table 19, is the small-scale nature of the effort. Few workers were both willing and eligible to participate. And it must be noted that while this programme was not exclusively directed at Johns-Manville, only one other worker is thought to have participated in it. There is no evidence that a serious effort was directed at having workers from other establishments participate.

I have read the files of about one-half of the participants in the SRAP. The record is a depressing one in terms of successful relocative efforts. The WCB can point to at least two reasons for this. Some of these men were unskilled, middle-aged or older and thought of themselves as being ill. They were hardly ideal candidates for success in the labour market.

Table 19

SPECIAL REHABILITATION ASSISTANCE PROGRAMME

FOR

JOHN'S-MANVILLE CANADA, INC.

STATISTICS AS OF DECEMBER 31, 1980

		TOTAL	PERCENTAGE
A. Total Known Asbestosis and A.F.D.E. Cases		80	100.00%
Breakdown:			
1. Asbestosis		31	38.75%
2. A.F.D.E.		48	60.00%
3. Unclassified *		1	1.25%
	Total	80	100.00%
B. Total Interviewed by The Team		67	83.75%
Total not interviewed by Team (includes cases previously active with V.R.D., also no shows and four (4) since deceased.)		13	16.25%
	Total	80	100.00%
C. Participation vs. Non-Participation			
1. Total electing to participate		18	22.50%
2. Total electing not to participate		36	45.00%
3. Total undecided		16	20.00%
4. Total subsequently deciding to withdraw (change in circumstances, reversal of former decision, etc.)		--	---
5. Unclassified *		--	---
6. Deceased		10	12.50%
	Total	80	100.00%

(continued)

	TOTAL	PERCENTAGE
D. Qualified For Entry vs. Non-Qualification In Terms of Hazardous vs. Non-Hazardous Employment at Time of Team Interviews		
Total number above who did not qualify as not in hazardous employment at time of team interviews	48	60.00%
Total number above who did qualify as in hazardous employment at time of team interviews	32	40.00%
Total	80	100.00%
E. Acceptance vs. Refusals		
Total number who did not qualify	48 *	60.00%
Total number (above) who refused programme outright	22	
Total number who qualified	32 *	40.00%
Total number (above) who refused programme outright	14	
Total number who did participate in programme	18	
Total	80 *	100.00%
TOTAL ACTIVE CASELOAD		
Breakdown:		
1. (a) In exposure	Nil	
(b) Out of exposure	33	
(c) Unclassified	--	
Total	33	100.00%
2. (a) Out of exposure participating and receiving T.P.D. or pension or combination	18	60.00%
(b) Off due to compensable reasons	Nil	- --
(c) Off due to non-compensable reasons	8	26.67%
3. On Training		
(a) Formal	3	10.00%
(b) Training-on-the-job	7	23.30%
4. Relocating	3	10.00%

* Referred by third-party interest.

Source: Prepared by the WCB

Additionally, the WCB believes that some workers were persuaded, on their own or by a union leader, that the programme was essentially a retirement programme. Thus, the staff encountered difficulty in persuading some of the participants that the effort was one of rehabilitation directed at returning them to work. This difference led to a continuing controversy between WCB staff involved in the scheme and some of the participants, exacerbating the ill-will that already prevailed. In any case, there appear to be few if any success stories based on the actual rehabilitation treatment.

It is beyond the range of this study to learn if the Elliot Lake project was successful or not. An evaluation of it would seem worthwhile, however, so that future SRAP's may learn from that experience as well as from the Johns-Manville case. Differences in a number of variables exist between the two cases, including the nature of the disease, the locations involved, and the co-operativeness of the unions involved. What may turn out to be as critical as any of these differences, however, is the availability of work with the same employer in a

non-exposed work site, such as the top-side at the mine. The comparison warrants examination for it appears very likely that the WCB will again undertake such programmes. In the absence of such programmes, efforts will be ad hoc. As an example of this latter approach, I was struck by a claim involving a 57 year-old pipefitter who was diagnosed as asbestotic and evaluated as 10 percent disabled. The WCB notified the employer, a large government agency, whose medical branch director was compelled to note, with obvious futility, "At your suggestion _____ has been removed as far as is practicable from further exposure to asbestos dust, however, he is a steam-fitter and some exposure will inevitably occur."

Chapter IX Summary and Conclusions

This study in its first eight chapters has been descriptive, with little commentary of an evaluative nature. In this chapter, I shall point to some of the areas that the Royal Commission and the WCB might consider with a view towards improving the functioning of the system. Some of these issues must be regarded as fundamental to the workers' compensation scheme in Ontario. Others could be implemented readily and simply. To help sort some of this out and to alert the reader to the significance of the issue, I have identified, arbitrarily, the considerations and issues below in terms of the type of impact possible changes would have on the overall system. While this seems to me to be a convenient device for exploring issues, the reader's attention, hopefully, will be directed to the specific issue at hand and not to whether my assessment of its significance is correct.

A. Major Policy Questions

a) No other issue has so consistently stirred controversy regarding workers' compensation for asbestos-related disease as has the basis for rating permanent partial disability benefits. The root of much of this dissatisfaction is the question of whether to employ either a disability or an impairment concept in the determination of the extent of entitlement. The existing approach is based fundamentally on impairment, consistent with the handling of all claims -- for injuries due to accidents or for other industrial diseases -- by the WCB. It would be difficult to rationalize some basic change in the handling of asbestos claims while leaving other claims such as back injuries unchanged.

The use of the impairment based approach leaves the WCB open to criticism by the public, the media and by others when impairment assessments deviate substantially from the extent of disability. The impairment approach places the burden of the decision on the medical staff and has left them open to most of the criticism I encountered of WCB practices. By contrast a strict disability oriented plan would mean that the many applicants at or near retirement age could be worse off than with the

existing scheme. Moreover, the many permanent disability victims who continue in their full-time employment could find a wage-loss scheme not to their liking. A combined type of programme, mixing impairment and disability, as exists for the miners in Quebec, is a possibility also.

Is the WCB's impairment approach the necessary product of legislative will (i.e., the statute), or does it derive from a preference by the Board where it has some flexibility? Were the WCB to express a preference for a disability or mixed-disability approach (as in mining in Quebec, for example), could it do so without amendment to the existing statute? This question has arisen in the past and is not peculiar to the handling of claims for industrial diseases.

The issue is summarized in a report of the Ombudsman's opinion regarding the pertinent section of the law (s.43 of the revised statute; previously s.42).* In short the Ombudsman found that the WCB

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* Ontario. Office of the Ombudsman. "Report of the Ombudsman's Opinion, Reasons Therefor and Recommendations Following His Investigation into Complaints Concerning the Assessment of Permanent Disability Awards Pursuant to Section 42 of The Workmen's Compensation Act," 17 February 1981.

had been interpreting this section too narrowly and recommended that "...the Board, in determining the impairment, is not limited to a consideration of the clinical rating, but may also consider any and all other relevant information when assessing a worker's impairment of earning capacity." The WCB rejected the recommendation and the Ombudsman then brought the matter to the Premier and to the Select Committee on the Ombudsman. The Committee appeared to side with the Ombudsman who then brought 130 complaints to the Board's attention on the issue of impairment assessment, finding that the WCB's decisions were "unreasonable." The Ombudsman recommended in February 1981, pursuant to this conclusion, that "...the Board alter its practice to take into consideration factors indicative of the actual impairment of earning capacity when assessing a worker's permanent disability award."

The WCB has subsequently brought this opinion to counsel and has been advised that its practices and interpretation of section 43 (previously s.42) are appropriate. Clearly this issue extends well beyond any question limited to asbestos-related diseases. It also seems evident that the matter is under considerable scrutiny from

many parties concerned with WCB activities. The matter will likely be decided eventually by the Legislative Assembly and not by the Ombudsman or the policy-makers at the WCB.

b) Whether the WCB uses either an impairment or a disability approach in evaluating the extent of compensation, a second critical question is how the WCB makes its assessment. Presently a worker's rating is based on the extent to which asbestos has contributed to a worker's impaired condition.

The ACOCD and the Medical Services Division appear to give little if any consideration to the extent to which the asbestos-related disease has aggravated or interacted synergistically with some other medical condition. It is not difficult to conceive of the case of a worker with a medical condition becoming severely impaired or disabled by contracting a mild degree of asbestosis. The current practice seeks to isolate only the impairment from the asbestos disease as opposed to the alternative of determining the extent of impairment resulting from both the direct and indirect effects of asbestos.

The matter of how broadly one is willing to explore the effects of asbestos disease is not strictly the result of the impairment approach and does arise even where disability is the condition determining benefit levels.

A well-known principle in many compensation jurisdictions is that "the employer takes the worker as he/she finds him/her." A pre-existing condition that would normally not be compensable becomes so when it is aggravated or accelerated by an injury or illness that arises out of and in the course of employment. This principle would allow the WCB to pay greater benefits, for example, where asbestosis causes a person with a cardiovascular condition to be more impaired or disabled than he would be in the presence solely of the asbestosis.

The problem of aggravation is particularly difficult to sort out in death claims. In practice very few jurisdictions would allow survivors benefits to be paid where an asbestos-related illness contributed, but trivially so, to a death. Assume, for example, that a worker dies from a condition

unrelated to asbestosis, but that his asbestotic condition hastened his death by a matter of a few days. Is this reasonable grounds to compensate a survivor and dependants? Regardless of the theoretical response to this, in practice compensation would likely not be sought from or paid by most compensation agencies. Since the concept of aggravation is not applied absolutely, the issue for these agencies becomes one of degree, and not of total acceptance or rejection of a principle. The presence of a lung disease is likely to weaken most individuals with other serious and potentially fatal conditions. Substantial numbers of survivors in Ontario have been compensated even where the worker did not die simply of asbestosis. Nevertheless, other potential beneficiaries have not been compensated due to the rather narrow and limited consideration given to the concepts of aggravation and/or acceleration.

B. Significant Policy Questions

a) For reasons that are not entirely clear, the WCB in Ontario has opted seldom to revise its list of industrial diseases (Schedule 3). Instead, the Board has preferred to add those diseases that it

wishes to consider as compensable by creating or modifying some guidelines. These guidelines, at least for some of the asbestos-related diseases, are no longer appropriate. This view is held by some key staff persons involved with them. Further evidence of this is where they are disregarded regularly by the WCB, as in the case of excessive exposure rules in the mesotheliomas. Also, it is noteworthy that none of the guidelines for asbestos-related diseases has been altered. Moreover, it must reflect some political reality that a particular set of existing guidelines, in place since May 1978, are still referred to as "provisional" despite the fact that the WCB can change any guidelines at will. In the writings of one Board doctor, "These guidelines are constantly being reviewed and updated as new information becomes available." Perhaps the WCB foresees some need to tighten up the guidelines and anticipates that to do this to "provisional" ones will be less controversial.

The WCB's asbestos guidelines may appear strict in some instances, but in others they are more liberal than those of many other jurisdictions, including the two noted in the study, British Columbia and Quebec. The guidelines are an appropriate issue

for debate by health specialists (e.g., epidemiologists, radiologists, etc.) and not by me. However, what does appear highly questionable are the procedures used to develop them. The most surprising of these, at least to me, has been the very narrow circle of persons involved with preparing them. No comments are solicited from the pertinent interest groups. Only two experts from outside the WCB have been involved in the various asbestos guidelines and one of these is the pathologist regularly used by the WCB on asbestos cases. The public is not even aware that specific guidelines may be under review. Opening the process of guidelines development need not prolong it. Nor must it necessarily subject the WCB to the opinions of uninformed, inexpert individuals. It is difficult to understand how an agency that has lived so much under public scrutiny has avoided becoming more open than it has in the matter of these guidelines in so controversial a field as industrial disease.

b) The extreme significance of the 100 percent disability rating, as it creates a guarantee of survivors benefits, has been noted. The WCB has been criticized in specific cases for being harsh to

survivors when the disability rating is less than 100 percent. The existing presumption is in the statute. It means that the WCB must confront two separate and very significant decisions when it finds a seriously disabled (impaired) applicant. First, should the claimant be judged 100 percent disabled or instead be rated at some fractionally lesser amount thereby eliminating the use of the presumption? Secondly, if rated below 100 percent, the WCB will eventually have to evaluate the cause of death and make a categoric decision on compensability. Since the WCB is often faced with difficult questions this is hardly grounds for changing the law or the Board's procedures. However, it does imply that survivors may lose potential benefits completely where the decisions are inherently difficult.

Various alternatives exist such as scaling down the level of the rating that brings into effect the presumption or adjusting the survivors benefit based on the impairment rating. Either of these, and related approaches, would have an enormous impact on workers' compensation unless they were limited to cases of asbestosis or industrial disease. An alternative that would not be so sweeping would be to

borrow the approach used in British Columbia; that is, to provide death benefits whenever a pensioner with asbestos-related disease dies from any natural cause involving the heart or lungs. An age limit on this presumptive type of approach could be applied, as British Columbia does.

c) Should every worker with an asbestosis claim be examined by the ACOCD? While Quebec does so, the Ontario WCB has screened claimants so that a significant number are not ever seen by either a Board doctor or the ACOCD. In some instances, the matter has involved some self-screening, such that the WCB's decision denied access to the ACOCD unless the person appealed. This sort of filter seems to be based on a premise that may be erroneous, namely, that if the condition exists or is bad enough, the worker will appeal an adverse decision.

The reason a claimant is denied access to the ACOCD (and to compensation) is because, presumably, the claim is so totally without merit as to constitute a waste of the ACOCD's time. Certainly that is the judgement of a single member of the Medical Services Division. This single decision,

made without actually examining the patient, is not reviewed by any other trained personnel. There are a number of ways that the WCB could move to modify this approach. Perhaps all applicants should have access to the ACOCD. Possibly the ACOCD could review the files of those claimants denied examinations. Other staff physicians might regularly review such decisions. The goal of any of these options is to insert additional professional opinion into a process that involves difficult, technical matters.

d) Similar questions are found in the handling of other asbestos disease issues that are not reviewed by the ACOCD. Two of these have been discussed earlier in this study. First, there are the claims for cancer which are almost always evaluated by Board doctors only. There are, however, guidelines for these and claimants are told of their rights to appeal when decisions adverse to them are made. Secondly, there are those fatalities of persons receiving benefits for asbestosis that do not result in survivors benefits. It appears to be a procedural oversight that potential beneficiaries are not informed that an appeal is available to them or

that they are not encouraged to bring forward evidence to demonstrate that the death was compensable. It is conceivable that some survivors even are unaware of their rights, potentially, to receive benefits for deaths from conditions identified as industrial diseases. While this may be rare, the WCB can easily inform survivors of their rights under the law.

e) The lack of indexation for inflation in temporary partial disability claims seems difficult to justify, especially since it may be a factor in keeping asbestotic workers under continuing exposure to asbestos. The costs of such an adjustment could not be very great as very few workers currently avail themselves of it, at least in the asbestos area. Many jurisdictions have encountered great difficulties in programmes designed to relocate sick or high risk workers away from certain hazards. Ontario is no exception to this. If more realistic benefits were made available in temporary partial disability cases, this would enhance the attractiveness of the relocation. An obvious place to begin this could be in the adjustment of the earnings base for inflation.

f) The WCB's Special Rehabilitation Programme failed for a number of reasons suggested earlier in the text. Many of the flaws were not the responsibility of the WCB. It would be the agency's failure, however, if it could not use the experience to learn why the programme encountered so many difficulties, and whether variations are possible that would be more likely to succeed. Rather than being pushed into another effort that is viewed as politically inspired, the WCB might consider planning rehabilitation programmes that would not be likely to fail. Initially the Medical Services Division might commission an expert to re-assess the literature on the health benefits of removing from risk persons with incipient asbestosis. Additionally it might meet with business and labour representatives to review various modes of action. Labour market experts might be consulted also. The WCB might even consider conducting some research on the progression of disease in persons participating in such programmes, thereby contributing directly to the scientific literature in this field.

g) The Royal Commission and the WCB need to consider the desirability of retaining an outreach programme. That effort resulted in rather few new

claims and only 2 accepted claims. The programme appears to have been phased out. This may be a wise use of scarce resources. At least one experience under the programme, however, suggests that it should be retained. One of the labour unions that was visited was the United Association of Journeymen and Apprentices of the Plumbing and Pipefitters Industry of the United States and Canada Union, Local 46, whose members are likely to benefit from information about WCB practices in asbestos cases. Although the union leaders were so advised in April 1977, by July 1980 a new leadership existed with no knowledge of the previous contact between the union and the WCB. Such situations are not rare and suggest that continuing contact with pertinent groups may be needed to assure that worthy claims eventually reach the WCB.

h) I have not investigated the procedures involved with the use of workers' advocates. It must be noted, however, that a very tiny fraction of asbestos cases appear to involve them, despite the inherent difficulties in adjudicating such claims. Earlier I described the paucity of appeals in asbestos-related claims. Even within that set the proportion of persons availing themselves of this

group is minimal. The WCB needs to review this matter to determine why workers are avoiding this method of support. For example, would the appearance of greater independence from the WCB be likely to encourage greater utilization?

C. Procedural Issues

a) A very significant criterion of the quality of a workers' compensation agency is the speed with which it processes claims. The Ontario WCB is mindful of this and appears to be proud of its record. Based on a recent survey (May 1981) by the WCB, the average time elapsed between receipt of a claim and cheque mailing is 9.9 work days. (This average, excludes fatal claims and industrial disease cases.)

Several parties in asbestos cases have complained to the Royal Commission or to me about the delays in processing claims for asbestos-related diseases. My access to specific claims files has given me the opportunity to observe the details involved in such claims. The Commission may wish to consider the following observations. The median time

time for a claim involving asbestos-related disease -- from initial submission to some type of resolution and notice to a claimant -- is about 6-7 months. The quickest are those that are rejected without examination by the ACOCD. The longer claims involve field examinations, perhaps to determine dust levels or the like, or reports from hospitals and doctors, many of whom appear co-operative but slow.

The ACOCD does not appear to be pressed to respond quickly. Lags occur both in scheduling examinations and in reporting their findings to the chest consultant and the WCB. Greater concern about promptness by the ACOCD could shave several weeks from the process but would not substantially shorten it.

The WCB could relieve itself of some criticism from clients by informing them of the progress of their claims. Specifically, claimants might be notified that their claims are still under consideration, that records are being sought, pathological inquiries are being carried out or other sources of delay are being encountered. While this will not

speed up the process, it may relieve many claimants of anxiety and frustration when the processing is drawn out. Generally there appears to be little the WCB can do to speed up the process (aside from the ACOCD issue) in these complex claims, and still provide equitable treatment to all parties.

b) This study has sought to identify the critical role played by the ACOCD in asbestos disease claims. This body has rendered an immense service to the WCB. One of its features represents both a virtue and a flaw. Earlier I described the very stable character of the Committee and the limited turnover that has occurred in it. On one side this provides the body with experience in both procedural and technical areas. It minimizes the chance of "horizontal inequity," that is, unequal treatment of equals.

This virtue of stability must be balanced against the potential that new ideas and experience are prevented from emerging. Turnover may be desirable even for its own sake on a professional

body such as this. It need not be radical but could, for example, involve replacing one member every one or two years or so. This would also force the WCB to define better than it now does its procedure for adding persons to the ACOCD. The fine balance between experience and fresh blood can be adjusted as the WCB chooses, through the formula selected for replacing Committee members.

c) There are no explicit procedures for the ACOCD to follow in evaluating asbestosis claims. The availability of guidelines for asbestosis would assist new members and consultants of the Committee. They would also serve to educate better representatives of interested groups in the role and functions of the ACOCD. They need not be so rigid as to limit the Committee's ability to operate. Instead, they could simply spell out the policies of the WCB with respect to adjudicating claims, impairment or disability considerations and the like. That no such document has emerged in the history of the ACOCD may explain why some critics of the WCB are poorly informed about this body.

D. Research Issues

a) One of the more prosaic aspects of compensating workers with asbestos-related diseases is the rating of permanently impaired workers. While this task is much less likely to bring the WCB into the public limelight than accepting a new disease as industrial, for example, it affects many workers and their families. It is difficult to assess how well this function is being performed, yet it is a key task for the WCB in respect of asbestos. One possible way for the WCB to assess the work of the ACOCD is to autopsy as many deceased asbestosis claimants as possible and review the findings in the light of the WCB ratings. Essentially, the study would review how the recent ACOCD decision compared with the condition of the lungs at time of autopsy. It could examine the lungs for the presence of asbestos fibres as well. Such a study would not be undertaken with a view towards changing awards; instead, it would serve to assist the Board doctors and the ACOCD in making future decisions.

b) Data on asbestos-related disease and workers' compensation are not in a form that can be

readily analyzed. Many of the pertinent data are scattered in the agency and the richest data are in pencil on index cards where they cannot be readily used. The WCB may find that increasing attention to certain issues, including industrial disease, will warrant having better data systems and in machine-readable form.

E. Other Observations

a) It may be surprising to some readers that a study on workers' compensation can give so little attention to the role of employers. As far as actual compensation practices in Ontario are concerned, this silence is not inappropriate. Other than providing records on employment and wages to the WCB, the employer plays virtually no role in the process. Of the 156 files on asbestos claims that were read, I found almost no employer participation, except occasionally to trigger the claims process by filing a Form 7-S before the worker filed his Form 6-S.

Employer appeals or dissatisfaction were rather rare, and were limited largely to denials that

exposures to asbestos occurred in their employ. These charges did not attack the legitimacy of the claim. Instead, they dealt with which employer bore responsibility, leaving the worker's claim unthreatened. An exact number of such occurrences based on the 156 files was difficult to establish since the matter was raised informally on several occasions, perhaps even in telephone conversations. Overall, it appears to have come up on fewer than ten occasions. I found that on a few occasions the employer acted in support of a worker in a dispute with the WCB.

b) A small number of claims files contain letters or records of telephone calls from holders of public office regarding claims. Typically, a member of the Ontario Legislative Assembly will enquire about the status of a claim or for information on why a claim was resolved as it was. Such enquiries usually receive special attention consisting of a letter from an official of the WCB or even its Chairman. I was sensitive to the possibility that the claim might receive some favoured treatment because of the attention that it received from some official or other. There does not appear to be any

basis for concern about favoured (or discriminatory) handling in such situations. The process is unaltered in such claims and no special pattern of decisions seems evident in these instances. Political involvement does not seem to help or harm claimants.

c) Some critics of the WCB believe that the agency acts as an adversary towards workers. They argue that the Board is motivated too strongly to save money by denying claims, thereby keeping employers' compensation costs down. Clearly, if one examines claims files there is always room to disagree with a judgement rendered by the WCB, or to second-guess the application of some practice. Moreover, the WCB is a very large organization that does not always move with great speed or grace. Yet in the handling of individual claims I found no basis for judging the Board so harshly. If some claims seemed to be resolved severely others seemed correspondingly generous or unquestioning. This judgement is obviously a personal one constructed only after carefully examining claims material. But my own views receive some corroboration from the very limited appeal activity I found.

The nature of this study is to assist the Royal Commission on Asbestos by alerting it to the problems that workers seeking compensation have encountered. That has meant some emphasis on practices that could be improved upon or at least reviewed. That emphasis should not obscure the fact that the WCB confronts an enormously complicated task in its treatment of asbestos disease cases, and that the agency has grappled with it conscientiously and fairly. It appears that the province has been well-served by it.

Ontario

Royal Commission on Matters of Health and Safety Arising from the Use of Asbestos in Ontario

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